Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month LYDTA MAE 135 A 99 28 4a. Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death BROOKFIELD MANOR RESIDENT CARE KEYMAR If Under 24 Hrs. CARROLI 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 95 Yrs. if Undar 1 Year Birthplace (Stete or Foreign Country) 6. Sex 1 M 2 F Months Days Hours Min 212-74-5174 SEPT. 23, 1903 MARYLAND Usuel Rasidence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND CARROLL DETOUR 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7535 MIDDLEBURG RD USA 14. Race - Americen Indien, Bleck, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give X Yaar or Dates: 1 Never Merried 2 Married 1 ☐ Yas 2 XNo Specify: Specify: 3 Nidowed 4 Divorced WHITE Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumama) **JOHN** WILLIAM KROM MAGGIE IRENE HOLLAND 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) SHIRLEY BURRIER (PER. REP.) 14760 SABILLASVILLE RD., THURMONT, MD 21788 20b. Plece of Disposition (Neme of cematery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) ZION CEMETERY 3/4/99 LADIESBURG, MD 21. Signature of Funerel Service License 22. Name end Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES. 615 EAST MAIN ST., THURMONT, MD 21788 23a. Past. Entar tha disease, or complications thet causad the death. Do not enter the mode of dylng, such as cardiac or respiretory errast, shock, or heert feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final diseasa or condition resulting in death) Due to (or es e consequence of): nory heart Sequentially list conditions, if any, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events rasulting In death) Lest Due to (or consequence of): Dua to (or es a consequence of): Part II. Other eignificent conditione contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □ Unknown 24b. Were autopsy findings aveilebla prior to 24e. Wes en autopsy completion of ceuse of death? 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one)

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-1 show other traumetic event, the Medical Examiner must be notified at

Hygiene.

permit. Peges 1 and 2 should be filled with Department of Health and Mental Hygient Important: If them 27 is marked other that any injury or other traumatic event, Imal 2005.

with the Marylend

death

hours efter

Baltimore, Maryland 21215-0020

/Medical

Director

Funeral

by

Completed

Be

2

the attending physician end hed for use es the buriel-tran À 90 been hes ebed certificate director : After this

The law requires that the death certificete be executed

P.O. Box 68760,

Records,

Division of Vital

the Hospital or Attending Physician:

Completed by Be P Certification:

25. Wes cese referred to medical exeminer? 1 Yes 2No 27. Manner of Deeth Naturel 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of ceptifian

Physician/Medical Examiner

within 24 hours efter deeth.

To the Funeral Director: All completely filled in by the fu Medical

> State Registrar

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 5 Pending investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work?

1 Tyes

28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

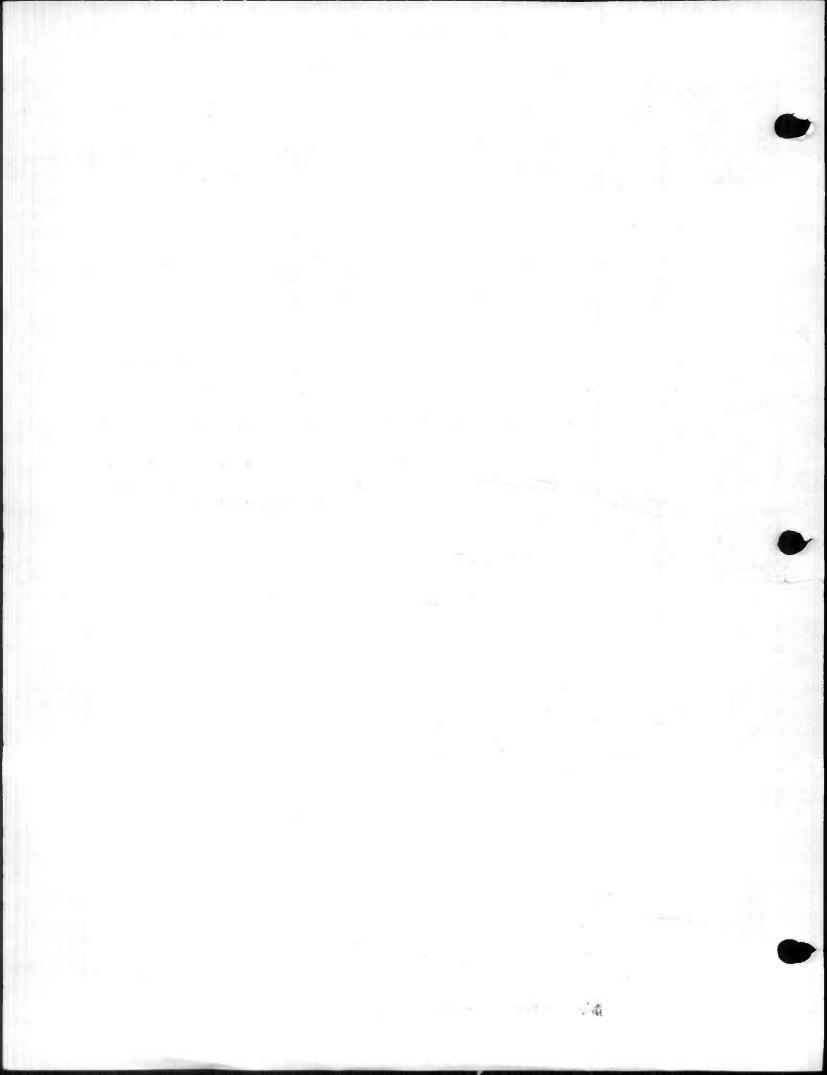
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted. 29c. Licanse number 29d. Qata signed (Month, Dev. Year)

28

s of person who completed cause of death (Item 23e) (Type, Print) 30. Name and affiding

ARICAFE 0, m 32. Registrer / Signeture 31. Date filed (Month, Day

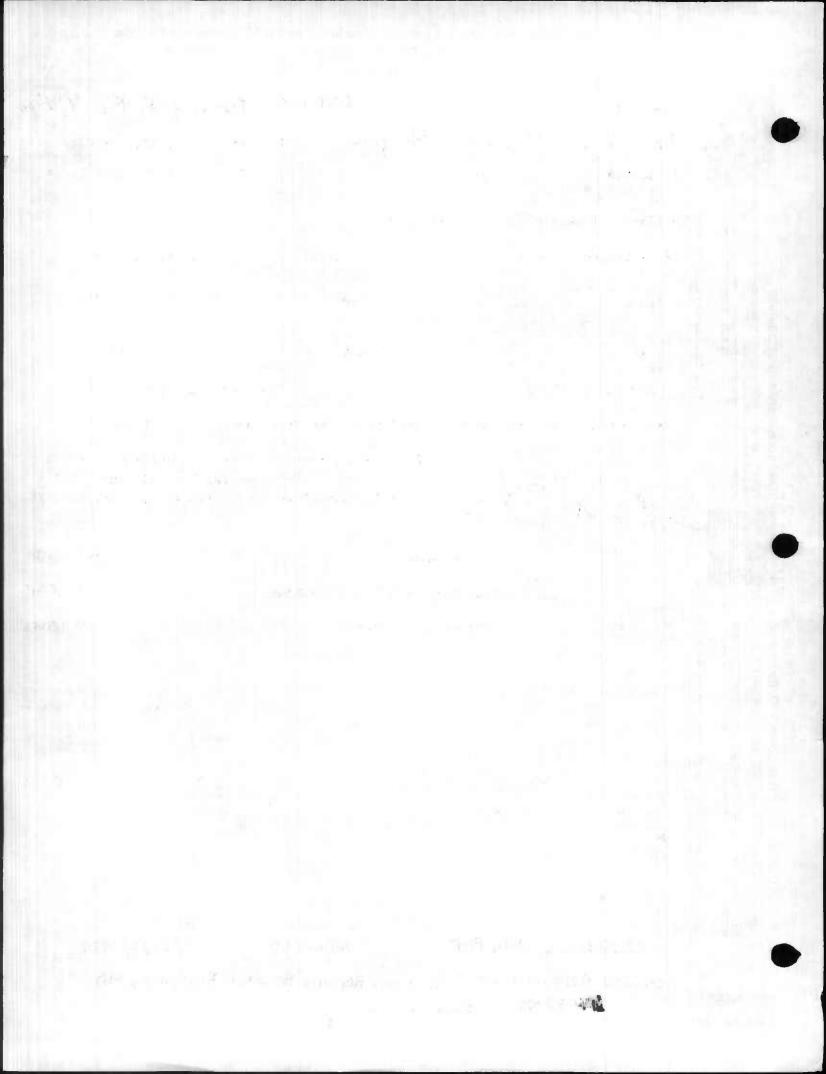
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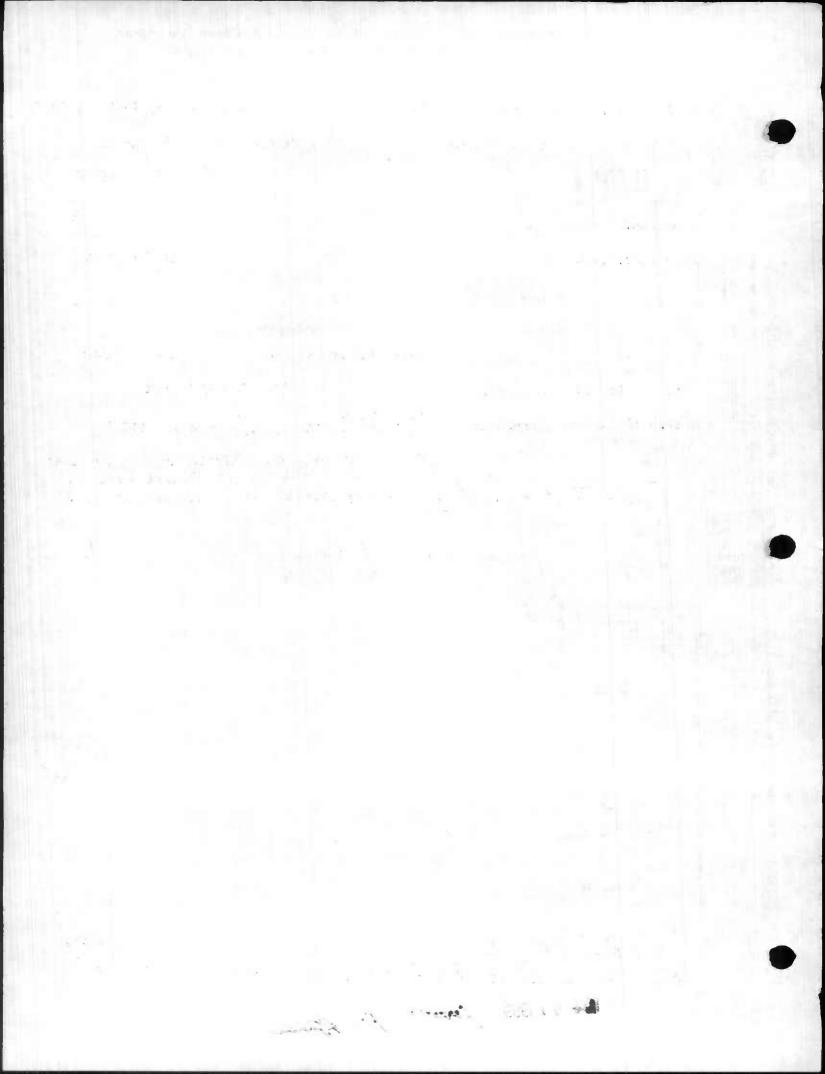
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Examiner	4e Fecility Neme (If not institution, given The Johns	Hopkir		10 11 11 11 11 11	4b. City, Town, or Baltin	more	Balti	imore		
uneral irector	5. Sociel Security Number 6. S 233-48-9847 Usual Residence of Decedent	Sex 7. Age I M 20 F 80	(In yrs. last birthday Yrs.	Months Deys		. (Month, D	irth lay, Year) 7, 1919	9. Birthpl Coun West	lece (State or Foreign try) t Virginia	
ta-f show utfact at ctor	10a. State 10b. County Maryland Freder	ick	10c. City, Town or L Jefferso				10d. Inside City Limits 1 ☐ Yes 2 ☒ No			
el, or items 23s or 28s-4 show Examiner must be notified at by Funeral Director	10e. Street and Number 4611 Newington 1	12. Wes Decedent E	ever in U,S. 13.	10f. Zip Code 21 Was Decedent of If Yes, specify Cul	755 Hispenic Origin? (Specify Yes or N	10g. Citizen of Whet Country? United States or No- 14, Race - American Indien.			
"naturel", or he	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:		If Yes, specify Cui		rto Hican, etc.)	Specify		ite	
dHo	15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12)	ducation ade completed) Coilege (1-4or 5-	(Give	edent's Usuei Occu e <i>kind of work done DO NOT</i> use <i>retin</i> Iomemaker	a during most of we	orking	16b. Kind of B	osiness/Ind	dustry	
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other traumatic	19a. Informent's Neme/Reletionship (Carole Craft Ic			Newingt			on, Mary	yland	21755	
ontant: If Its Injury or of	20a. Method of Disposition 1 💆 Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Special Service Laborators)	y) <u>0</u>	Ft. Line	omatory or other place of Ceme	tery	3/4/99	Brenty	wood,	Maryland	
clan	23a Parri. Enter the disease or com shyde, or heart feilure. List only	She	16	21 Oposs	umtown P	ike Fre			land 21702 Approximete Interval Between Onset end Deeth	
dical niner	Immediate Ceuse (Final disease or condition resulting in death) e. UREMIA Due to (or es e consequence of): b. Coronary Artery Disease									
Cian/Medical Examination	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest	c. Diak				2 years				
tached hysi	Pert ii. Other significant conditions of	contributing to death bu	t not resulting in the	underlying cause g	iven in Pert I.		3b. Did tobacco usa contributa to the cause of de			
sete has been signed, page 2 should be de Completed by P						per	s en eutopsy formed?	co	ere eutopsy findings eilable prior to mpletion of cause deeth?	
irector o Be	25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospitai:	nt 2□ER/Outpatie	ent 3 DOA	ther	eeth (Check only	Yes 2 □ No one) sidenca 6 □Oth		Yes 2 No	
7	27. Manner of Deeth 1 ANaturel 5 Pending 2 Accident investigation	28e. Dete of Injur (Month, Day		of 28c. fnj		1	how injury occur		"	
□ < 0	3 ☐ Suicide 6 ☐ Could not be determined	building, etc			r, office 28f. Location (Stree City or Town, S			Street and Number or Rural Route Number, m, Stete)		
completely filled in b	(Check only 2 Medical Examone)	yelcian: To the best o ninar: On the basis of end manner ste	examinetion end/or in	nvestigetion, in my	opinion, deeth occ		, date end pieca,	and due to	the cause(s)	
00	. 0000	, MD, Pr		RES	5 - 000		29d. Date signe 02/21			
State	30. Name end address of person who HOSS EIN ARDE 31. Dete filed (Month,	HALL, MD,	PhD, Jor	ins Hopk		ital, Ba	ultimore	, MO)	
Registrar	37 0 2	1999 ^{32. Registra}	apera	B. A	soul!					

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State of Maryland / Department of Health and Mental Hygiene	0.800
Cortificate of Dooth	

					Cert	ificate of	Death		Reg. No.			
		1. Decedent's Name (First, Middle, Las	st)					2. Data of De Month	eath Day	Year	3. Time of Death	
Physicia /Medica		JEAN ELIZABETH	KINSEY	LANT	ΓZ			Februa		1999	8:30 PM	1
Examine		4a Facility Name (If not Institution, give	street end number)				4b. City, Town, or	Location of Daar	th 4c. County	of Death		
8		Northampton Mano					Frederic		Frede			
Funeral Director		5. Social Security Number 6. S 213-24-8049 Usual Residence of Decedent	ex 7. Age ☐ M 2X F	(In yrs. lest	Yrs.	If Undar 1 Yaa Months Days			rth ay, Yaer) 1931	9. Birthp Coun Mary	place (Stata or Forai http) Land	ign
pue Ma		10a. State 10b. County		10c. City, T	own or Loca	ation				1	I Od. Inside City Limi	its
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With with	ā	1473 Mobley Court				2170	1		Unite	d Sta	1101	
me 2;	era	11. Marital Status	12. Was Decedant E	ver in U,S.	13. W		l Hispanic Orlgin? (ban, Mexican, Pue	Specify Yes or N		e - Amaric	can Indian,	
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thin 72 hours after an "natural", or	Completed	15. Decedent's Ed (Specify only highast gra	ucetion de completed)	1	6a. Decede	nt's Usual Occu	pation during most of w	orkina	16b. Kind of Bi	usiness/In	dustry	
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1 end Health Fm 27 ther tr	-	Deborah Taulton /	aaugnter	20h Plac	3815 1	Bedford	Drive, J	efferson	2, MD 2	1755 City or To	own State	-
namit. Pages 1 e Departmant of Hei mportant: if item iny injury or othe		1 N Burial 2 Cremation 3		Cem	etery, creme	etory or other pl	ace)	0/07/00	- 1	1 11	. 0 1	
amit. Pages 1 end Department of Health Important: if Item 27 any Injury or other to	-	4 Donation 5 Other (Specify	-	Kesi			lGardens					_
parmit. Departimontal		21. Signature of Funeral Service Licen	1/				rass of Facility St					
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Physician /Medical		Immediate Causa (Final	0	,		11				-	13	
Examiner		diseasa or condition rasulting in death)	a lac	Ma	me	y N	ang			1	Lins	
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ysician: Tha is is certificate he director, page		25. Was cese referred to medicel					DC Blace of D			11	Ties SEINO	
Physician: r this certific and director,	o Re	examiner?	Hospital: 1 ☐ Inpatian	4 2 D E B	/Outpatient	3□ DOA C	Whor:	eath (Check only Home 5 Res		nor (Spani	64)	_
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or Attendi	lica	3 ☐ Suicide 6 ☐ Could not be		ry - At home	a, farm, stra	at, factory, office	a.			ber or Rur	ral Route Number,	
effer Dire	Certification:	4 ☐ Homicida datammed	building, etc.	(Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	own, Stete)			
pours ours fille	S S	29a. Certifier 1FT Certifying Ph	ysician: To the best of	my knowle	dge, death	occurred at the	time, date and pla	ce, and due to the	a causa(s) and m	annar as s	stated.	
To the Hospital or Attending Physimin 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral d	edicai		niner: On the besis of and mannar stat	examination								
o this o the	Σ	29b. Signature and title of certifier)	29c. Licar	nse number		29d. Date signe	d (Month,	Dey, Year)	
F > F 0		Dol 1. 4	25 11.	. 1		D	05	111	21	26/	199	
		30. Name and address of person who	complated cause of de	att (Item 25	Ba) (Type D	rint)					701	_
		Dr. Robert S.	Hughes 70	0 Mô	ntcx	aire A	venue F	rederi	ck, Md.	217	01	
State	e	31. Date filed (Month, Date (15)	32. Registra	r' Signatur	9			 				-
Registra	-	MAK ()	1 1999	More	~	6.	bout					
HMH 16 Rev 6/95						1	The state of					



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** LAFRATTE 2:13 PM MARIE ELLEN **FEBRUARY** 24, 1999 /Medical 4c. County of Deeth Frederick 4e Facility Name (If not institution, give street and number) Frederick Memorial Hospital 4b. City, Town, or Location of Deeth Frederick **Examiner** Hours Min. April 14, 1925 7. Age (In yrs. last birthday) If Under 1 Yeer 9. Birthpleca (Stete or Foreign County) Land 5. Social Security Number 215-14-1820 **Funeral** 1□M XXF Months Deys Yrs. Director Usual Residence of Decedent the Meryland 10d. Inside City Limits 10e Stete 10b County 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or itema 23a or 28a-f sho traumatic event, the Medical Examiner must be notfled at 1 GYes 2 No Frederick Director Frederick Maryland 10e. Street end Number 901 Walnut Street 10f. Zip Code 10g. Citizen of Whet Country? 21702 U.S.A. Funeral deeth permit. Pages 1 and 2 should be filed within 72 hours after deet Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural." And any injury or other traumatic averages. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☑No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Meritel Status 1 Nevar Married 2 Married White 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grede completed) College (1-4or 5+) Elementery/Secondary (0-12) Manafacturing company Assembler 18. Mother's Name (First, Middle, Meiden Sumema) 17. Fether's Neme (First, Middla, Last) Mamie Warfield George W. Dixon OL 19e. Informant's Name/Relationship (Type, Print) Alfred LaFratte/Husband 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State Zip Code)
901 Walnut Street, Frederick, MD 21702 Feb. 27, 20e. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State Mount of Twee of the place ery 1999 Frederick, MD 1 Burial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal a of Funaral Service Licensas 22. Name end Address of Fecility Keeney & Basford Funeral Home 23a. Part. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest.

MD

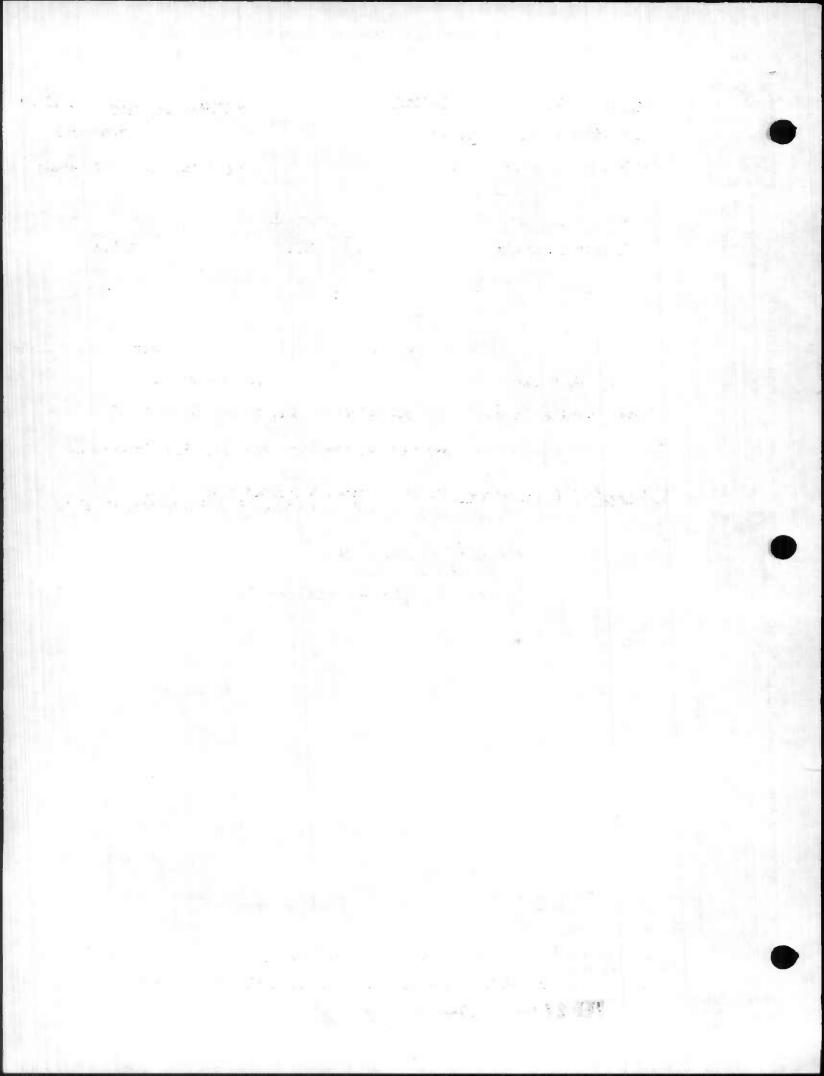
23a. Part. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. 21701 Approximate Interval Between Onset end Death **Physician** /Medical Immediata Causa (Finel diseese or condition resulting in death) Examiner Examiner sician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attanding physician Physician/Medical the Due to (or es e consequence of) 98 Part tt. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy peen has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Netural 5 Pending investigation 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 ☐ Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 ☐ Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. edical 29a, Certifier (Check only one) 29b. Signeture and title of certifier 29c. Licensa number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert S. Hughes, M.D., 700 Montclaire Ave., Frederick, MD 21701

State Registrar 31. Date filed (Month

B. Spark



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Deeth Year Month **Physician** STEVEN LUBEZNY NMN 3:00 A.M. February 23, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick 1794 Stonehaven Lane Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F Yrs 342-16-9733 Director 79 28, 1919 Illinois Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mentel Hyglans. Important: If item 27 is merked other than "natural", or items 23s or 28s-1 show with july or other treumstic event, the Medical Examples must be notified at PASE. Yos 2□No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zio Code 10g. Citizan of What Country? 1794 Stonehaven Lane United States 21702 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

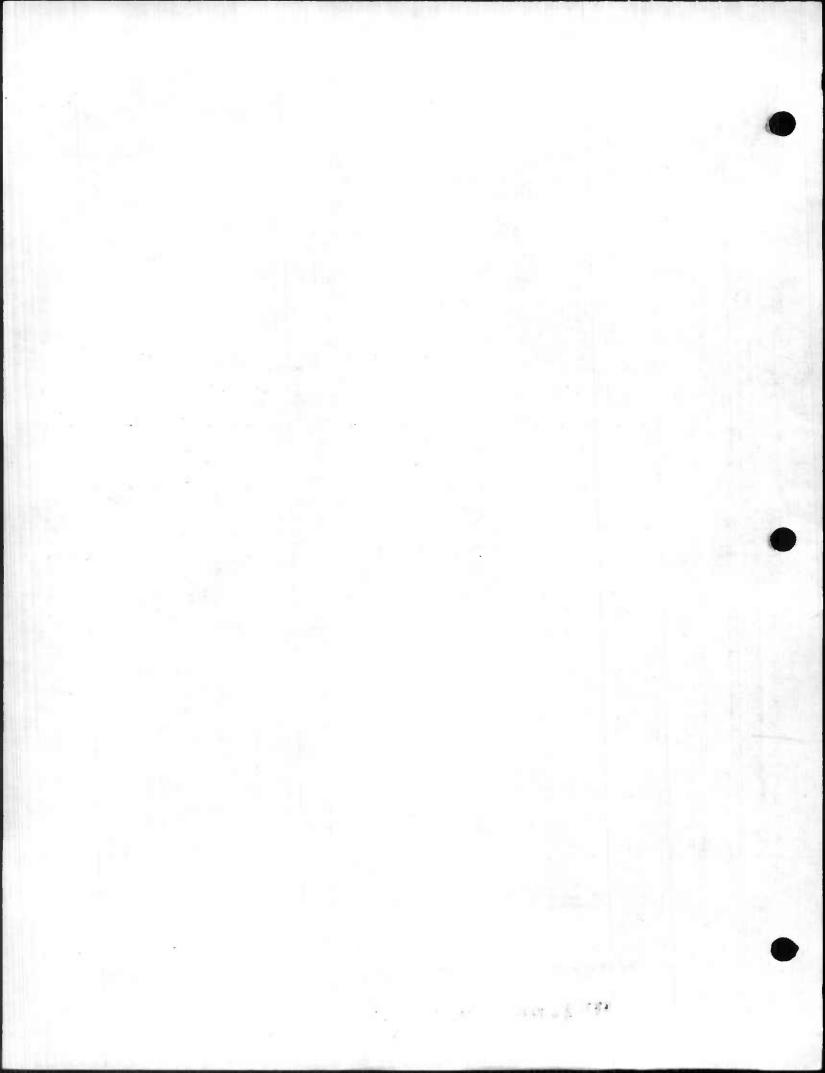
1 K Yes 2 No
1 Yes, Give
Year or Dates: WWII 14. Race - Amarican Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 XWidowed 4 ☐ Divorced Completed 16a. Decadent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Industrial Engineer Conveyor Baltimore, Maryland 17, Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) 8 John Lubezny Anastasia Tzynaiko 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Olga A. Rurka, sister 2555 Hawthorne Westchester, Illinois 60154 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nicholas Cemetery 2/27/99 Chicago, Illinois 22. Name and Address of Facility
Stauffer Funeral Homes, P.A. 21: Signature of Funeral Service License 1621 Opossumtown Pike Frederick, Maryland 21702 Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate intervel Between Onset and Death Physician /Medical Immediata Cause (Final Years disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner sician and burlei-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buriel Box 68760. Physician/Medical Due to (or as a consequence of): 2 987 jo Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Alcoholism signed t þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 1 ☐ Yes 2 X No 1 Yes 2 No certificate Division of Vital or Attanding Physician: 80 25. Was case refarred to medical axaminer? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Homa 5 🕱 Rasidence 6 ☐ Othar (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending To the Hospital or Attanding within 24 hours etter death.
To the Funeral Director: Afticompletely filled in by the fun 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) end mannar as stated.

2 Idedical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signal 29c. License number 29d. Data signed (Month, Day, Year) and title of certifier February 23, 1999 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1080 W. Patrick St. Frederick, MD 21703 Jr, MD TAR ICX

State Registrar EB (

2

32. Registra/s Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month JOHN. WARREN MOORE Sr. 27,1999 February 5:25 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Dorchester General Hospital Cambridge Dorchester 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) Deys 100 M 2□ F Yrs 180-18-9586 76 Pennsylvania Usual Residence of Deceden 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes X No Maryland Dorchester Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3026 Steamer Run Road 21613 US 12. Was Decedent Ever in U,S. Armed Forces? WXYes 2 □ No If Yes, Give Year or Detes: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad 16e. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Crane Operator Steel Industry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Taylor H. Moore Edna M. Hummel 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary E. Moore 3026 Steamer Run Road Cambridge, Maryland 21613 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gulph Christian Cemetery 3/4/99 Upper Merion TWP, PA 21. Signatury PyFuneral Service Ligenses 22. Name end Address of Fecility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 10 23e. Party Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in deeth) ONIGE Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequenca of): 23b. Did tobecco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 28. Place of Deeth (Check only one) Hospitel: 1-Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident

Examiner Examiner burial-transit and P.O. Box 68760, attending physician Physician/Medicai the 98 ò signed by t Records, à Be Completed Division of Vital P After this To the Hospital or Attending within 24 hours effer death. Director: within 24 hours eff
To the Funeral Di
completely filled in

Physician

/Medicai

Examiner

Director

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Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

pernit. Pages 1 and 2 ahouid be filed withir Dispariment of Health and Mental Hygiene important. If item 27 is marked other than any Injury or other traumetic event. Be 14-

Physician /Medicai

Saltimore, Maryland 21215-0020

Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner's 1 Yes 2 No 27. Menner of Deeth 1 Naturel

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signatupe and title of

6 Could not be determined

3 Suicide

29a Certifier

4 Homicide

12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piaca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) and menner steted. 29c. License number 29d. Date signed (Month, Day, Year)

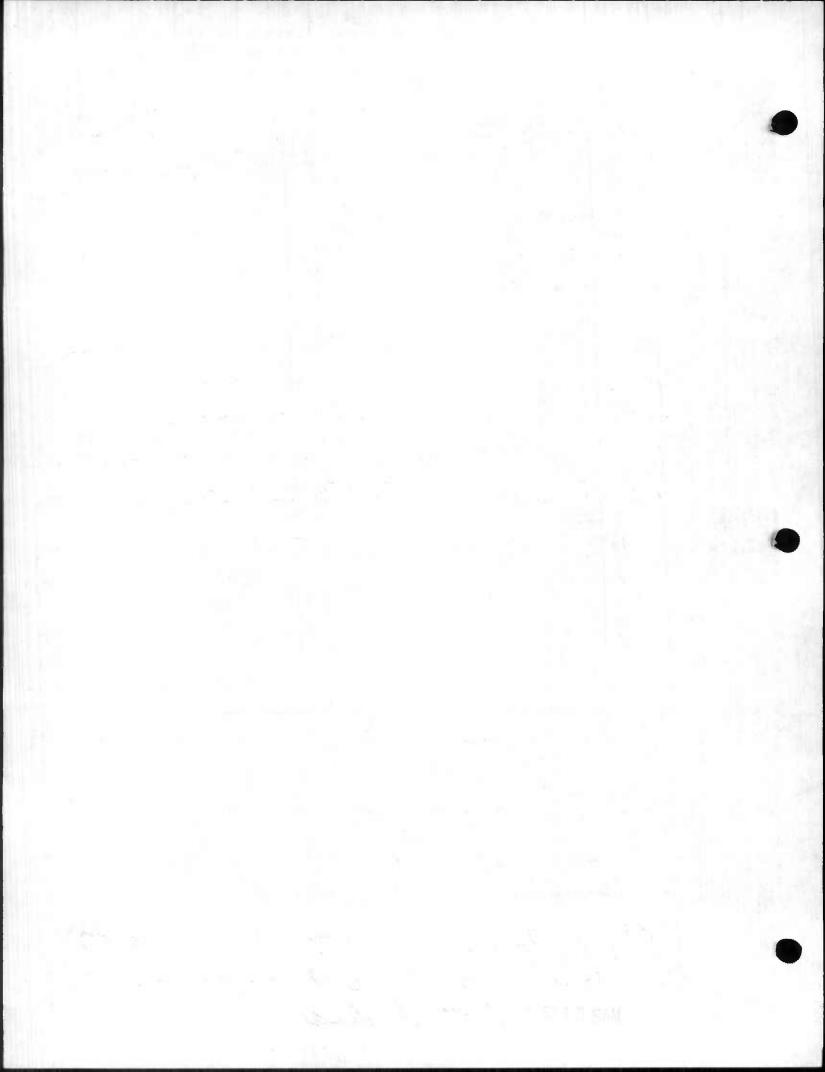
ne end edd ho completed cause of deeth (Item 23a) (Type, Print)

State Registrar

Medical

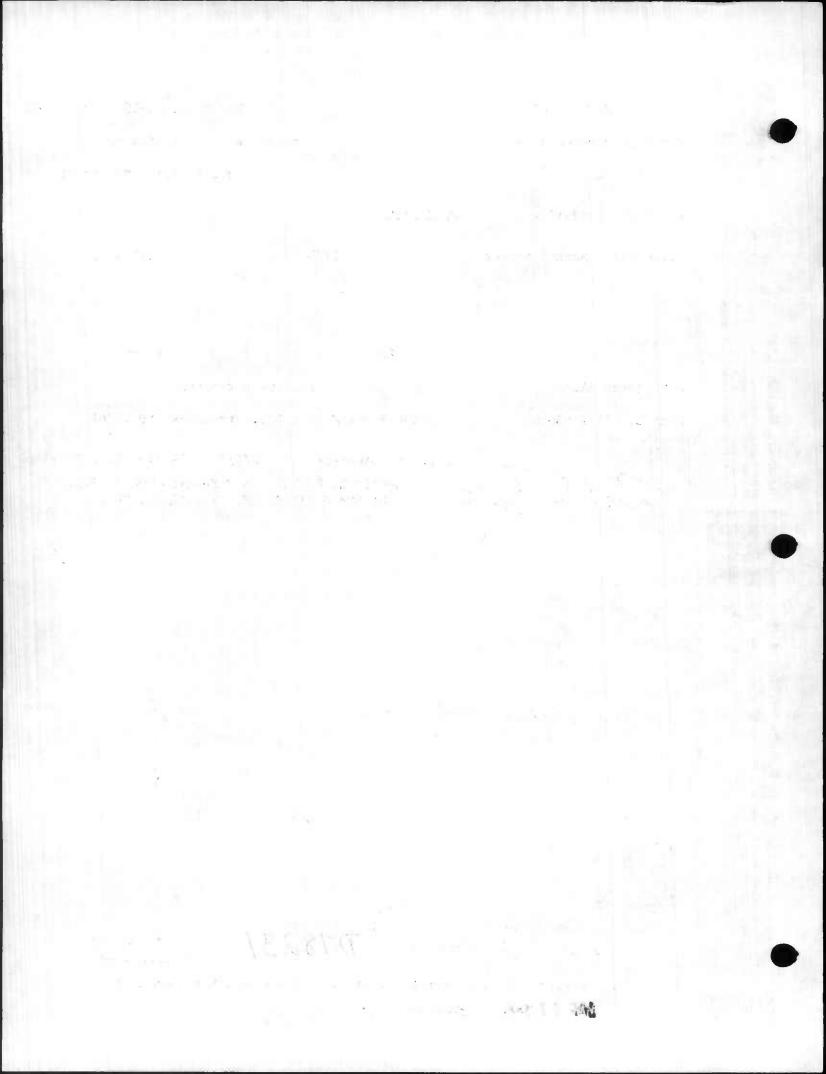
31. Dete filed (Month, Day, Year) 1999 MAR 0 1

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 99 0807

					Ce	rtificat	e of	Death			Reg. No.			
		1. Decedant's Nama (First, Middle	a, Last)							2. Dete of Dea	ath Day	Yeer	3. Time o	f Death
н	Physician	ESKER M	ILLS							March	1, 19		9:30	AM
	/Medical Examiner	4a Facility Nama (If not institution	n, giva straat and nu	umber)				4b. City, To	wn, or L	ocation of Death	4c. County	of Death		
di.	LAdminici	Citizens Nursin	g Home					Fre	deri	ck	Frede	lerick		
	Funeral	5. Social Security Number	6. Sax	7. Aga (In yrs. la	st birthday)	If Undar		If Undar	24 Hrs.	8. Data of Birt (Month, Da		9. Birthp	laca (Stata	or Foraign
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		Usual Residence of Decedent		00						21011	, 1712	10111		
	lend	10a. Stata 10b. County		10c. City,	Town or Lo	ocation						1	0d. insida C	Ity Limits
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21215-0020	natural', referal Ex	3A Widowed 4 Divorced		Datas:							101 101 1 10		hite	
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10	de la	19a. Informant's Name/Ralations				_				ral Routa Numbe				
	12 t	John E. Mills (Son)		1186	North	n Ma	rket	St.,	Freder	ick, MD	21/0)1	
<u> </u>	5 5 2	20a. Method of Disposition	. 55		aca of Disponatary, cra	osition (Nar	ne of othar pla	ca)		Data	20c. Location	City or To	own, Stata	
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	n 24 hours n 24 hours ne Funeral I pletely filled edical Ce	29e. Certifier (Check only 2 Medicat	ng Phyalcian: To th Examiner: On the t	besis of examineti										(s)
	To the Hospital or Attending R within 24 hours eler death. To the Funeral Director After completely filled in by the Anna Medical Certification:		and med	nner stated.		1100	n Lines	ea number			29d. Data sign	ad /Adams	Day Vaart	
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		Robert L. Kaufn	nann, MD	300 West	t Nint	th Sti	reet	, Fre	deri	ck, Mar	yland 2	1701		
	State	31. Date filad (Month, Day, Year)	0 9 1000	Registrar' Signat	ura	1		1						
	Registrar	WAK.	בבבו א ה	1 June		D.	10	DOL A	41					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 3. Tima of Death 2. Data of Death **Physician** March 1, Day 999 Yaar 0700 McGINNIS Robert Hugh /Medical 4c. County of Death Frederick 4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Frederick 131 Water Street If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Aga (layrs, last birthday) Birthplaca (State or Foreign Country) **Funeral** 1**∆**M 2□F 217-12-2691 Yrs. Director July 9, 1914 Tennessee Usual Rasidance of Decedant death with the Marylend 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show Frederick Frederick Maryland 1 Yas 2 No Director 10g. Citizan of What Country? U.S.A. 10e. Streat and Numbar 10f. Zip Code 6 21701 131 Water Street items 23a Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. White 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours effer t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumetic event, the Medical Experiment 1 Navar Married 2 Married 1 ☐ Yas 2 PNo Specify: Baltimore, Maryland 21215-0020 Completed by 3 ☐ Widowad 4 ☐ Divorced 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Carpenter Construction 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Be Hugh R. McGinnis Dora Nelson 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Emily McGinnis/Wife 131 Water Street, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete Date Mt. Olivet Cemetery 1 GBurlal 2 Cramation 3 Ramoval from Stata March 3, 1999 Frederick, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Nama and Addrass of Facility
Keeney & Basford Funeral Home M00021 106 East Church St., Frederick, Maryland 21701 23a. Part1. Entar the disease, or complications that feaused the death. Do not entar the mode of dying, such as cerdiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. **Physician** CARCINOMATOSIS /Medical Immediata Causa (Finel diseasa or condition resulting in daath) **Examiner** Examiner ARCINOMA physician end s the buriel-trensit The law requires that the death certificete be executed Sequantially list conditions, if eny, laading to Immediata causa. Entar Underlying Ceuse (Disaasa or injury that Initiatad avents resulting In daath) Last P.O. Box 68760, Be Completed by Physician/Medical Due to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown accident Records, Parkussois syndrome 24b. Wara autopsy findings available prior to complation of cause of deeth? 24a. Wes an autopsy performed? Hyprox Reusion certificate 1 Yas 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

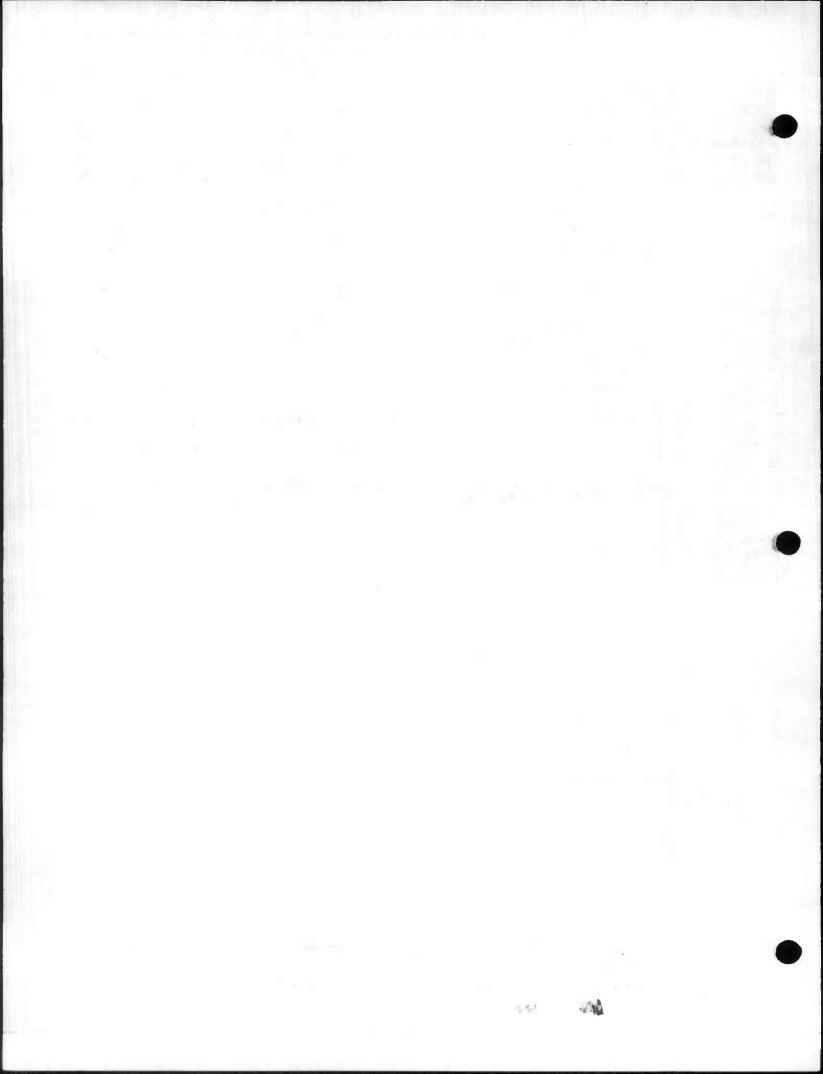
To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was cesa rafarrad to medical axaminer? 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 1 Yas 2 No Other: 4 ☐ Nursing Homa 5 Rasidence 6 ☐ Other (Specify) 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding invastigation 1 Natural NA 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined 3 Suicida 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Spacify) Location (Streat and Number or Rural Routa Number, City or Town, Steta) 4 Homicida 15 Certifying Physiclen: To the best of my knowledge, death occurred at the time, dete and place, end due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. Medical 29a. Cartifiar 29b. Signatura and title of certifier 29c. Licansa number 29d. Deta signed (Month, Day, Year) D18063 March 2, 1999 30. Nama and addj ss of person who completed ceuse of death (Item 23e) (Type, Print) Abdúl Majeed, M.D., 801 Toll House Ave., Frederick, Maryland 21701

32. Ragistrar Signature

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month. Da



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Tima of Death Month **Physician** 9:25 pm Thomas February 27, 1999 Albert. McCracken /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner College View Center Frederick Frederick If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yea If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foraign Country) Days MM 2DF 91 Yrs. 214-10-1596 Maryland Usual Rasidance of Dacedeni 10a Steta 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 N Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 810 Montclaire Avenue 21701 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ᡚ No If Yas, Giva Year or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 Navar Married 2 Married 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Spacify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Operating Engineer Federal Government 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Be Thomas William . McCRACKEN Clara STAUB 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. Howard Zimmerman/P.O.A. 642 Grant Place, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Removal from Stata Mount Olivet Cemtery Mar 2,1999 Frederick, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service Lice 22 Name and Address of Facility Keeney & Basford P.A. Funeral Home M00706 106 East Church Street, Frederick, MD 21701 Part 1. Entar tha disease, or complications that causad the death. Do not antar tha mode of dying, such es cardiec or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Immedieta Causa (Final disaasa or condition resulting in death) ~ sophaged 3 MONTH) Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or Injury that initiated avants rasulting in daath) Last Due to (or es e consaguança of) Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Ware eutopsy findings evailabla prior to complation of causa of deeth? 24a. Was an autopsy performad? Completed 1 ☐ Yes 2 ☐ No 25. Wes case rafarred to medical axaminar? 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ Yas No Othar: Surring Homa 5 Residence 6 Othar (Specify) Medical Certification: To 1 Inpatiant 2 ER/Outpatiant 3 DOA 28e. Data of Injury (Month, Day Year) 27. Mennar of Deeth 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Straet end Number or Rural Routa Number, City or Town, State) 4 Homicida Descritifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and pleca, and dua to tha causa(s) and menner as steted.

| Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. 29a, Certifia: 29b. Signatura and titla of certifian 29c. Licanse number 29d. Date signad (Month, Dey, Yaar) D09689

300 W Ninth St, Frederick, Maryland 21701

State

30. Name end addrass of person who completed cause of death (Item 23a) (Typa, Print)

Austin

31. Data filed (Month, D

Pearre, Jr. M.D., R.O. 1995^{2. Ragistras Signature}

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter to Department of Heelth end Mental Hygiene. Important: If Itam 27 is merked other than "naturel", or ther any injury or other traumetic event, the Medical Examina-

Physician /Medical

Examiner

-transit

pue

ettending physicien for use as the burie

signed by t

been s hes certificate

To the Hospital or Attanding Physician: within 24 hours after death.

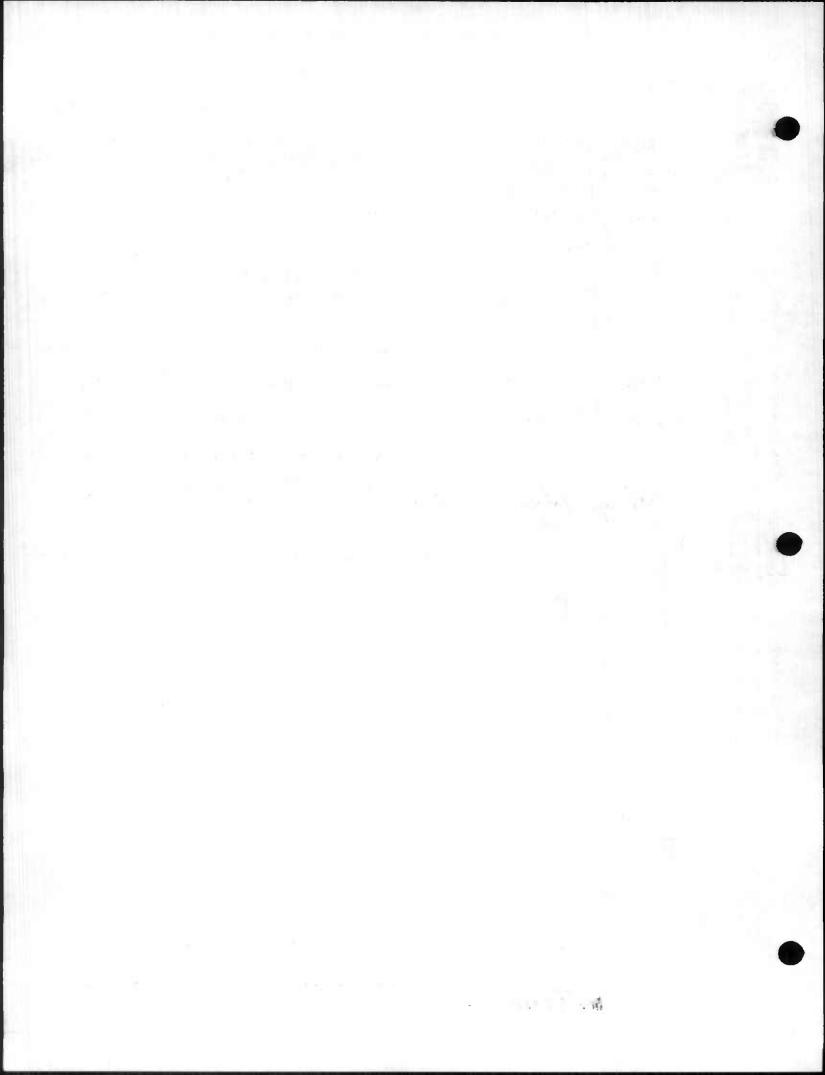
To the Funeral Director: After this certifics

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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Registrar **DHMH 16 Rev 6/95**



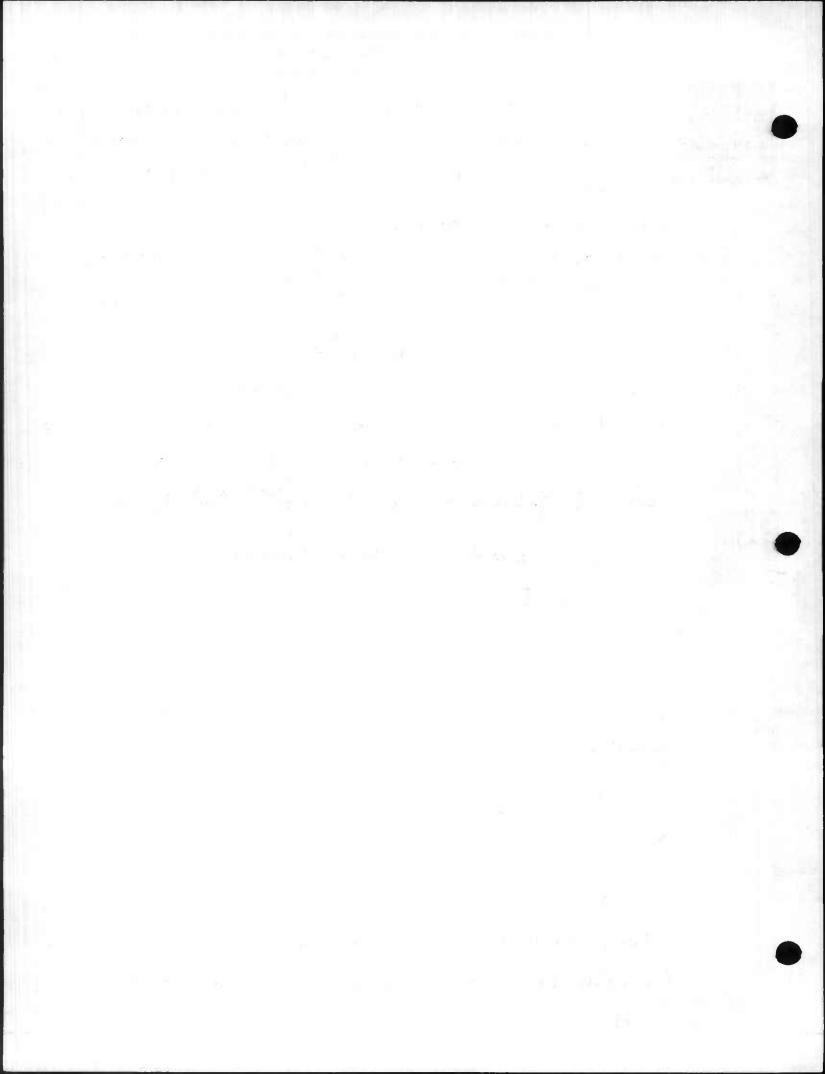
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Feb. 25, Grace Evelyn Miller 1 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Retirement Center Frederick Frederick If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth Month, Day, July 23, 7. Age (In yrs. iast birthday) Birthplace (State or Foreign Country)
 M **Funeral** Days Hours 1 □ M 2 T F 218-24-9674 90 Yrs Director Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f show edical Examiner must be notified at Completed by Funeral Director MI. Frederick Middletown 1 ¥ Yes 2 □ No 10e. Street and Number 10g. Citizen ot What Country? 10f. Zip Code 112 W. Main St. 21769 U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer of and of Health and Mertell Hygiene.
Int: If flem 27 is marked other than "natural", or feel inty or other traumatic event, the Medical Estandinal inty or other traumatic event, the Medical Estandinal. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No It Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorcad 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbur M. Ahalt Mamie Elizabeth Younkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn F. Biser (Daughter) 7811 Flook Rd., Middletown, Md. 21769 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or once. Lutheran Cemetery 2/28Middletown, Mi. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licanses 22. Name and Address of Facility
Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence ot) P.O. Box 68760, physician s the buria Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 210 No 3 Probably 4 Unknown signed b Records, þ ebrovascular disease 24b. Were autopsy findings available prior to page 2 should Completed 24a. Was en autopsy performed? completion of cause of death? certificate has 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certificately filled in by the funeral director, p. Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 20 No Certification: To 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a, Certifier within 24 hour To the Funer completely file Medicai To the 29b. Signeture and title of carly 29c. License number 29d. Date signed (Month, Day, Year) ROESS CER WWD POBOK 17 MIDD LETOWN, WO. 21769 30. Name end address of perso 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AR 0 2 1990 Registrar

DHMH 16 Bay 6/95

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	Examir		4e. Fecility Neme (If not institution, give					4b. City, Town, or					
			Shady Grove Adv		-	_		Rockvil		Mont		-	
	Funeral Director		5. Social Security Number 6. Sec. 213-01-6821 Usuel Residence of Decedent	x 7. Age (In y 83	rs. last birthda Yrs.	Month	ler 1 Year s Deys	If Under 24 Hrs Hours Min.	(Month, De	by, Yeer) 0, 1915		ece (Stete or Foreig try) cyland	ın
	Mon Mon		10a. Stete 10b. County	10c.	City, Town or	Location					10	Od. Inside City Limits	5
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Maryland 21215-0020	72 hours efter deeth with the Maryland "natural", or items 23a or 28a-f show adical Examinet must be notified at	by Funeral	11. Marital Stetus 1 □ Never Merried 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	U,S. 1			dispante Origin? (Sen, Mexicen, Puerl Specify:	specify Yes or No to Rican, etc.)	Specify	en Indien, etc.		
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re,	f Health tem 27 other tr		20e. Method of Disposition		. Plece of Dis	sposition (N	eme of	y Court,	Dete	20c. Location -			
Baltimore,	permit. Pages 1 end Department of Health Important: if item 27 eny injury or other tr once.		1 ☑ Buriel 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emover irom State	orest (27/99	Caithar	chura	, Marylan	
alti	mit. I partm portar r inju		21. Signature of Funeral Service License		JIEST (ess of Fecility	21/99	Galther	Sparg	, marylan	Ia
m	Depa Impo any is		VOlin In	I leave the		1in I	. Mo	lesworth	P. A. F	uneral	Home	20070	
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Box	deeth cer e ettendin ed for use	an		l							-		-
	the eth	sici	Pert II. Other significent conditions con	tributing to death but not r	esulting in the	underlying	ceuse giv	ven in Pert I.	23b. Did	tobacco usa coi	ntributa to	the causa of death	17
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on	ding h. After funer	tion	1 Naturel 5 ☐ Pending	28e. Date of Injury (Month, Dey Year)	28b. Time Injury		28c. Injui Wo	rk? Yes 2 □ No	260. Describe	how injury occur	ea		
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27. Menner of Deeth Square Square													
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month MARY ELIZABETH MOORE FEB 22 1999 3:30 am /Medical 4a. Fecility Nama (If not institution, giva street and number) 4h City Town or Location of Deeth 4c. County of Deeth Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Sociel Security Number If Under 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplece (Stete or Foraign Country) 8. Deta of Birth (Month, Dev. Year) **Funeral** 1 M 2 F Deys Yrs. Director 097-28-1531 JULY 7 1933 NEW YORK Usuel Residence of Decedent the Maryland 10e Stete 10h County 10c. City. Town or Location "natural", or items 23s or 28s-f show 10d. Inside City Limits 1 Yas 2 □ No Director MD MONTGOMERY GERMANTOWN 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 18609 GLEN WILLOW WAY 20874 U.S.A. death Funeral Was Decedent Ever in U,S. Armed Forces? Was Dacadent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indien, Black, White, atc. d 2 should be filed within 72 hours efter th end Mentel Hygiene.
7 Is merked other then "netural", or fler traumatic event, in a Medical Exercities. 1 Tyes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2☑No If Yas, Give Yeer or Detes: Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest greda complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE HEALTH CARE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Peges 1 end 2 should be in ant of Health end Mentel | JOHN EDGAR PITT HAZEL WINSTEAD 19e. Informent's Neme/Ralationship (Type, Print) important: If item 27 is a sny injury or other traum once. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DANIEL MOORE / SON 18609 GLEN WILLOW WAY GERMANTOWN, MD 20874 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ENDERS/SHIRLEY F.H. BERRYVILLE, VA 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility HILTON FUNERAL HOME BOX 86 BARNESVILLE, MI 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart feilure. List only one ceuse on each line. 20838 Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final MULTISYSTEM FAILURE disease or condition resulting in death) Days Examiner Due to (or es e consequence of): Examiner Days HYPOTENSION The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest pue Due to (or as e consequence of): Days physicien is the buriel RENAL FAILURE P.O. Box 68760, Physician/Medical Due to (or as a consequence of): SEPTICEMIA 98 980 Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by d be detect 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Records. þ 24b. Were autopsy findings aveilabla prior to completion of causa of deeth? Completed 24a. Was an eutopsy performed? pege 2 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 25 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation 1 DNeturel 1 ☐ Yes 2 ☐ No death. s efter death I Director: / d in by the f 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide within 24 hours e To the Funeral D Hospital edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier (Check only the 29b. Signature end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 22,1999 30. Name end address of person who completed out of deeth (Item 23a) (Type, Print) JOHN E. KELLY, MD 2401 RESEARCH BLVD. #340 ROCKVILLE, MD 32. Registrar Signature **2 4 1999** State

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DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Time of Deeth Dav Month Yaar 2:25 PM 1999 TARCH 01 4c. County of Death 4b. City, Town, or Location of Daeth Takoma Park Montgomery If Undar 24 Hrs. If Under 1 Year 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foraign Country) Months 1QM 2QF Davs Hours 90 June 13 1908 Pennsylvania

1. Decedant's Nama (First, Middla, Last) **Physician** Joseph J. Mikita /Medical 4a Facility Nama (If not institution, giva straat and number) Examiner Washington Adventist Hospital 5. Sociel Security Number **Funeral** 094 01 9191 Director Usuel Rasidance of Dacedant the Manyland 10a Stata 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 20782 United States 5821 Oueens Chapel Road death 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural" or han injury or other trainment. 1 Yas 2 No 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yas ₽ No Specify: Specifiwhite à 3€ Widowed 4 Divorced Year or Detes: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grade complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Chemical Engineer $5 \pm$ Dupont Corp. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Julia Pal Joseph Mikita 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Margaret Addis- granddaughter Turner Turner Road Lusby Maryland 20657 20c. Location - City or Town, Stata camatary, cramatory or other place March
Thmopson Mem Cemetery 5 1 Deurlal 2 Cremetion 3 Ramoval from Stata New Hope Pennsylvan 4 Donation 5 Othar (Specify) 21. Signatura of Funaral Sarvice Licensaa 22. Name and Addrass of Facility Rausch Funeral Home PA 4405 Broomes Island Road Port Republic MD 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediata Causa (Final diseasa or condition rasulting in daath) Julmonar **Examiner** Examiner Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants resulting In daath) Last as a consaquance of) and Division of Vital Records, P.O. Box 68760 physician 4 Dua to (or as a consequance of): attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

Physician/Medical 2 ď Bengis þ 9 Completed 0000 has 50000 cortificate Be To

2 Certification: Alter d or Attending after death. I Director: All

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27. Manner of Daath

2 Accidant

4 Homicida

29b. Signatura and till

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29a. Cartifian (Check only one)

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25. Was casa raterred o madical 26. Placa of Death (Check only ona) axaminar

Hospital: 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 5 Panding invastigation

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28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Yas

24a. Was an autopsy

1 Yes

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

2 No.

1 Yes 2 No 3 Probably 4 Vinknown

24b. Wara autopsy findings availabla prior to complation of causa of daath?

1 Yas 2 No

10d. Insida City Limits

206,7,6ate

Intarval Batween Onsat and Death

1 Yas 2 No

1 Certifying Physicien: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year) 29c. Licansa number D 18895

Pess of parson who complated causa of death (Itam 23a) (Type, Print), RALL KARAMA PARK, MARYLAND 1999 32. Ragistrar's Signatura 31. Data filed (Month.

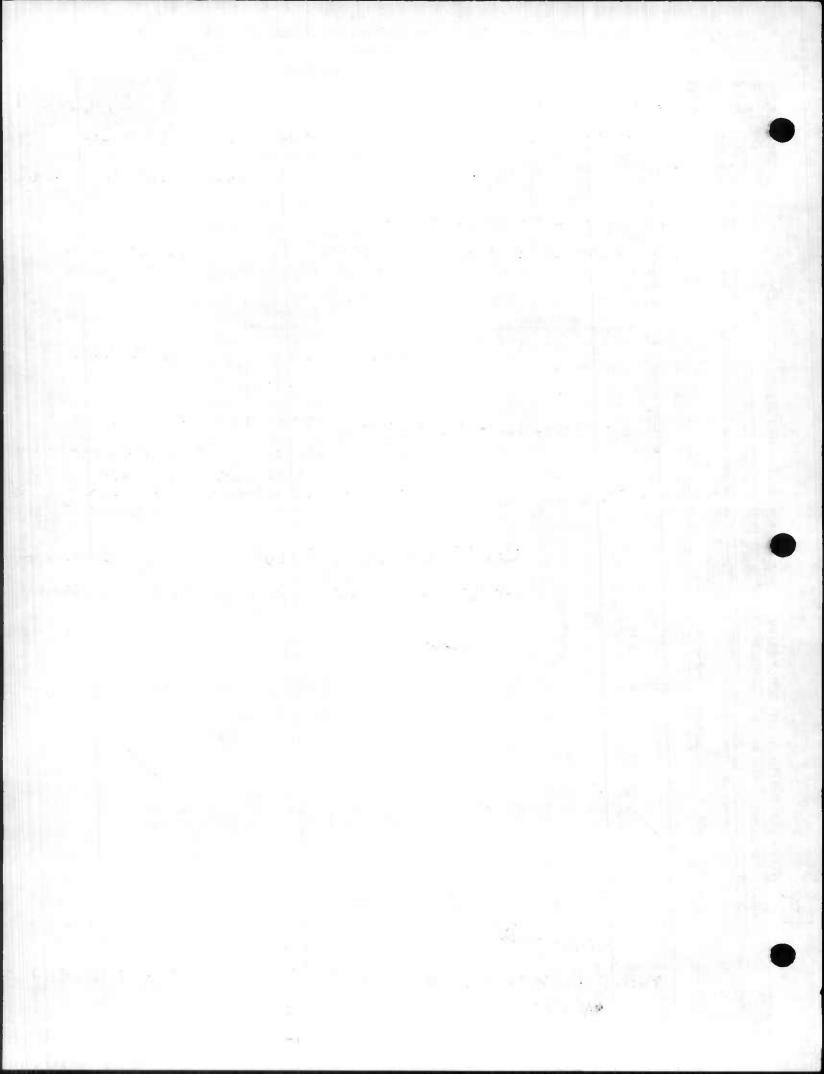
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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Data of Deeth 3. Time of Deeth Month Dey Yeer FEBRUARY 27, 1999 **Physician** WILBUR EWEN **MCPHERSON** 1315 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Undar 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) Oct. 22, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (Stata or Foreign **Funeral** 1√2 M 2□ F Days Months Hours 86 Wash., 578 46 1407 Director Usual Residence of Decedent with the Marylenc 10c. City. Town or Location 10d. Inside City Limits 10a. Stete 10b. County 7 is marked other than "natural", or flams 23a or 28a-f show traumatic event, the Madical Examinar must be notified at Calvert Huntingtown 1 ☐ Yas 🏞 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1975 Kings Landing Road 20639 USA Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mentel Hygiene. Important: if flem 27 is marked other than "natural", or flem any injury or other traumatic event, the Medical Exercised DRES. Bleck, Whita, etc. 1 Never Marriad 2 Married white Saltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: þ 3 DoWidowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) machinist U.S. Government 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) McPherson Duncan Campbell Pauline Pittman 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Barbara J. Thompson/daug. same as 10 above 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete XXBuriel 2 Cremetion 3 Removal from State Cedar Hill Cemetery 3-2-99 Suitland, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Nama end Address of Facility Rausch Funeral Home, Owings, MD 20736 23e. Pert1. Enter the disease, or complications that complete shock, or heart tailure. List only one ceuse on another. e daath. Do not enter the mode of dying, such es cardiec or respiretory errest, Approximate Interval Between Onset end Deeth **Physician** /Medical immediate Ceuse (Finel diseese or condition resulting in deeth) Accident Jdays (erebrova Suler Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed physician end s the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that Initiated avents resulting In deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Dua to (or es a consequance of): 8 esn Po signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 3 thknown Hypertensum þ Division of Vital Records, 24b. Were autopsy findings aveilable prior to 24a. Was en eutopsy performed? Completed Cerebrovasunor disease completion of cause of death? hes 2 No 1 Yes 1 ☐ Yas 2 ☐ No certificate or Attending Physician: funeral director Be 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To After this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? 5 Pending Investigation 1 Naturel 1 Yes 2 No 24 hours after death. 2 Accident 6 ☐ Could not be determined 3 Sulcida 28e. Place of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner es steted. edicai (Check only one) 2 Medical Examiner: On the basis of axaminetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. within 2 \$ 29c. License number 29d. Data signed (Month, Dev. Year) 29b. Signeture end title of certifier 0 ewins, ms D47313 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOYCE L. OWENS, M.D., DUNKIRK, MD 20754 31. Dete tiled (Month, Dey, Year)

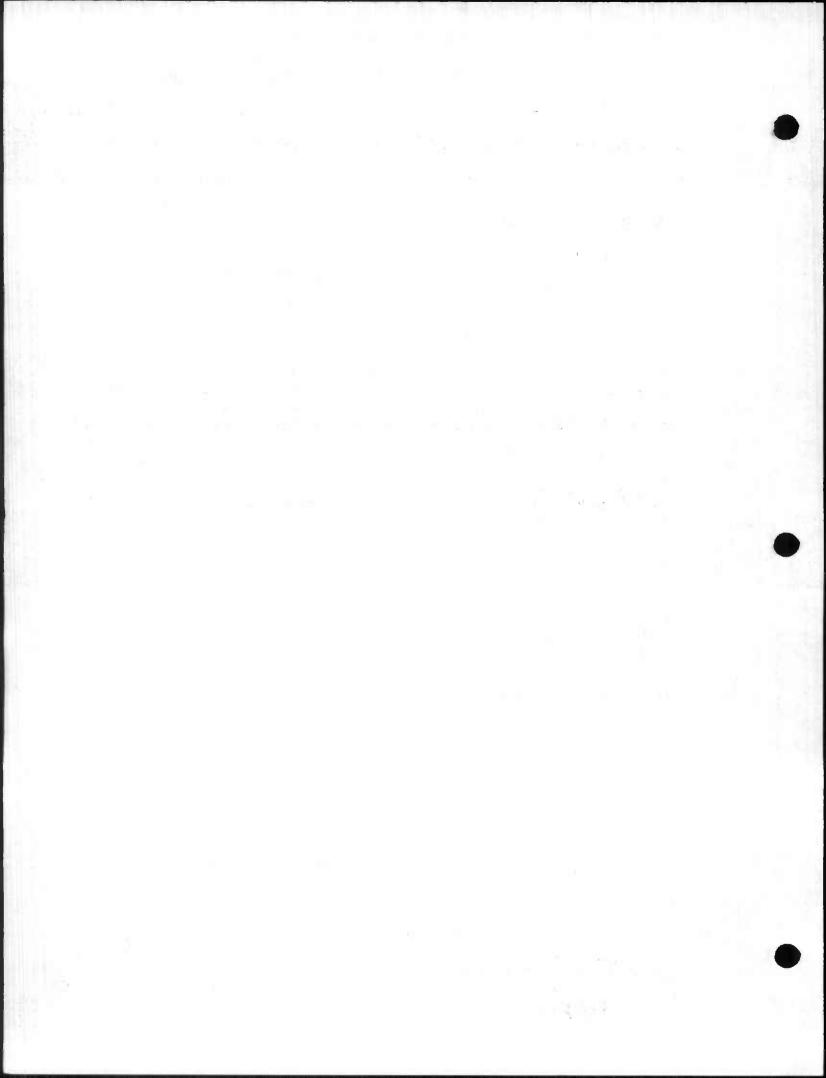
State Registrar MAR 0 1 1999 Serve

B. Sparks

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and N Certificate of Death		eg. No.	0 (3015					
Г	Physici	an	Decedent's Neme (First, Middle, Last)	2. Dete of Deer Month	th Dev	Yeer	3. Time of Death					
1	/Medi	cal	FANNIE MAY MARSHALL 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Li	February		1999	9:30 a.m.					
	Examir	ner 	Millennium Health & Rehabilitation Center Edgewater			Arunde	el					
	Funeral Director		5. Social Security Number 218 11 9519 6. Sex 1 M 2 N F 94 1 M 2 N F 94 1 M Onths Deys Hours Min.	8. Defe of Birth (Month, Dey, June 19	Year)	9. Birthpier Country Deale	ce (Stete or Foreign					
Т	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				I. Inside City Limits					
	Manyl H sho	to	Maryland Anne Arundel Deale				1 ☐ Yes 2 No					
	th with the 23a or 28a	al Director		1	0g. Citizen of V US.		п					
0020 nours efter de	n 72 hours efter deeth with the Maryland "natural", or items 23s or 28s-f show edical Examinet must be notified at	by Funeral	If Yes, Give 1 ☐ Yes 2 No Specify: Year or Detes:	ecify Yes or No- Rican, efc.)	Bled	14. Rece - American Indien, Bleck, Whife, etc. Specify: white						
Maryland 21215-0020	Jene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) 7 16a. Decedent's Usuel Occupation (Give kind of work done during most of work) (iffe. DO NOT use retired) homemaker	orking 16b. KInd of Business/Industr OWN home			stry					
pug	d be filed antal Hygid (ed other c event, the	Be	17. Fether's Neme (First, Middle, Last) 18. Mother's Neme	10.								
II y	d 2 should be th and Mantal 7 Is marked of traumatic ev	2	Thomas Franklin Welch 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rur	Mae		Deale	hadal .					
	nd 2 alith a 27 ls		Mrs. Ida Mae Williams / daughter P.O. Box 190, 621 De									
Baltimore,	m - = 0		20e. Mefhod of Disposition 1 Buriei 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) Deale Family Cemetery 02	Date 2-27-99	20c. Location -		n, Stete					
Balt	permit. Pages Department of Important: If I any injury or		21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Hom	ne, P.A.,	, Owin	gs, MI	20736					
			23e. Pert1. Enfer the disease, or complications thef caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heert feilure. List only one ceuse on each line.	or respiratory arm	est,	ir	approximata interval Between Onsef and Deeth					
A.	Physician /Medical Examiner		Immediate Cause (Finei disease or condition resulting in dath) All Manager of Condition resulting in dath)									
	P #	lner	Due to (or as a consequence of):									
50,	iceta be executed physicien end s the burial-transit	I Examiner	Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Oiseesa or injury									
x 68760,	certificeta I nding physi use es the t	/Medical	thet initieted events resulting in deeth) Last Due to (or as a consequence of):									
. Box	or its	iciar	Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.	23h Did to	hacco use co	ntribute to ti	he cause of death?					
, P.O.	that the led by th detache	y Physician/M		1 □ Y			bly 4 □ Unknown					
Records,	aw requir as been s 2 should	Completed by		24e. Wes e perform	n autopsy ned?	svella	autopsy findings able prior to pietion of cause ath?					
	The ate h			1 □ Ye	s 2 No	101	Yes 2□ No					
Vital	Physician: The this certificate ral director, page	o Be	25. Wes case referred to medical examiner? 1 Yes 20 No Other: 4 Nursing Ho									
on of	Attending Physic death. ector: After this by the funeral d	ation: To	1 Yes 2D/No 1 inpatient 2 ER/Outpatlent 3 DOA 1 Norsing Ho 27. Manner of Deeth 1 Norsing Ho 28a. Dete of Injury 1 Norsing Ho 28b. Time of Injury 1 Norsing Ho 28c. Injury at Work? 1 Yes 2 No	ome 5 ☐ Reside 28d. Describe ho								
Division	al or Attendi s after death. Il Director: A ed in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicida 6 ☐ Could not be determined 28e. Plece of Injury - At homa, ferm, street, fectory, office building, atc. (Specify)	28f. Location (St City or Town		er or Rural F	loute Number,					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Certifying Physicfan: To the best of my knowledge, daeth occurred at the time, date end plece, 2 Madicat Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred and menner steted.	end due to the ce red et the time, de	eusa(s) and ma ete end plece, o	nner as stet end dua to th	ed. na causa(s)					
	To the to	Σ	290. Signature and title of certifier D / 25 /	2	9d. Dete signed 2 / 2	6 / 9	y, Year)					
6	3		30. Name and address of person who completed cause of death (florm 23a) (Type, Print)	MI)	207	76					
	Sta Registra	re.	31. Dete filed (Month, Per Bar) 6 1999 32. Registrer's Signetura		1		10					

DHMH 16 Rev 6/95

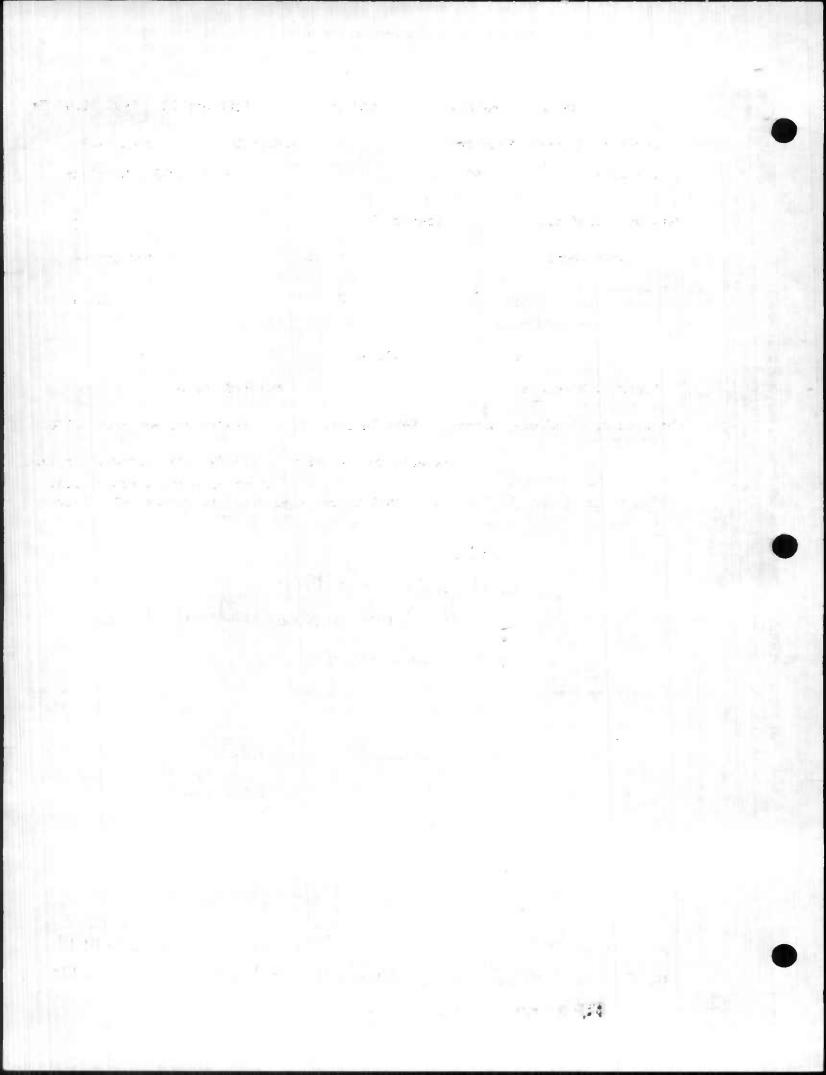


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State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificate	of i	Death		R	eg. No.			
	1. Decedent's Name (Fire	st, Middle, La	st)		TIM					2. Dete of Deel		Voer	3. Time of	Death
Physicia /Medic		Roge	r Fu	1ton	Ni	codem	us			February	7 22	1999	11:08	PM
Examine	An Challing blaces offered	nstitution, giv	e street end numb	er)			4	4b. City, To	wn, or Lo	cation of Deeth	4c. County	of Death		
A)	Frederick	Memor	ial Hosp	ital				Fre	deri	ck	Fr	eder	ick	
Funeral	5. Social Security Number		Mu offe	Age (In yrs. la		If Under	1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey,	Year)	9. Birthp Cour	lace (Stata o	or Foreign
Director	214-48-4614		201	50	Yrs.				1	Nov. 6,	1948	Mary	land	
and *	Usual Residence of Dece	County		10c. City.	Town or Lo	ocation						1	0d. Inside Ci	ity Limits
denyti es	Maryland F	rederi	ck	Fr	reder	ick							1 ∑ Yes	2 No
289-	10e. Street end Number	rederi	.CK	FI	euer.	10f. Zip	Code			1	Og. Citizan of	Whet Cour	ntry?	
with a second	8010 Reed	Court					217	0.2				- 17		
leath me 23	Maryland F 10e. Street end Number 8010 Reed 11. Maritel Status 1 🖾 Never Married	Court	12. Was Decede	ent Ever in U,S	. 13.	Was Decede	ent of H	lispenic Orl	gin? (Spe	ecify Yes or No-	Unite	e - Amario		
r Her	1 Never Married	2 ☐ Married	Armed Force			If Yes, speci	ry Cube	en, Mexicar	i, Puerto	Rican, etc.)		ck, White,	etc.	
urs a	3 □ Widowed 4 □ [Divorced	If Yes, Give Year or Dete	es:		1 ☐ Yes 2	. No	Specify:			Specif	v: Wh	nite	
naturel',		Decedent's Ed			16a. Dece	dent's Usual	Occup	ation	t of work	ing	16b. Kind of B	usinass/In	dustry	
d within 72 hours at giene. Ir than "naturel", or	Elamentary/Secondary	-	completed) College (1-4	or 5+)	life. DO NOT use retired,			e during most of working red)						
	0		4		Aud	ditor					200 70	nk		
be filed that Hyg d othe event,	17. Fether's Neme (First,	1100								a (First, Middle, I	Meiden Sumer	ne)		
should be filed and Mental Hygi marked other umatic event, I	Roger N.	Nicod	emus						Mild	red Cru	ım			
0 0 0 0	19a. Informent's Name/F	Relationship (Type, Print)		19b. Maili	ng Address	(Street	and Numb	er or Run	al Route Number	r, City or Town	, State, Zip	Code)	
CENE	Mildred C.		emus, mo			l Glen		e Dri	ve	Frederic				01_
8 5 2 5	20a. Method of Disposition		Removal from Sta	000	n <i>etery, cr</i> e	osition (Nem matory or of	her ple	ce)	1	Dete	20c. Location	- City or 10	own, Stete	
emit. Pages 1 al Department of Heal moortant: If Item: Iny Injury or othe	4 Donetion 5 0		**	Ная		own Cr	-			/24/99	Hagers	town	Mary	1and
permit. Page Department of Important: If any Injury or pnce.	21. Signature of Funeral	Service Licer	1500		2:	2. Name and	Addre	ss of Facili	Sta	uffer Fu	uneral	Homes	s, P.A	
005ed	Navemo	nd	tele	was					n Pi	ke Fred	derick,		21702	
	23a. Puttl Eyler the dis	ease, or com ure. Liet only	plications that cau	sed the death. h lina.	Do not an	ter the mode	a ot dyir	ng, such as	cardiac	or respiratory err	est,		Approximat Intarval Bet	te tween
Physician	/											i	Onset end	Death
/Medical Examiner	Immediate Causa (Final disease or condition resulting in death) e.									1	YRS	3.		
	Due to (or es a consaquence of):													-
po tis	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CMV quotantially list conditions, if any, leading to immediate cause. Enter Underlying											DEC	98	
icate be executed physicien end sthe bunal-transit											0000	0		
be ed be e	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events													
requires that the death certificate be executed requires that the death certificate be executed even signed by the attending physicien end hould be detached for use as the bunal-transit	resulting in deeth) Last										1	,	-	
ath certifica attending pl for use as t	≥ //	- 6	d. Ker	nal -	fau	ure	•						1 mo	IN
attendi	Part II. Other significant		11		U					L ook Dida				-404-046
that the de ned by the s detached	Part II. Other significant	h but not result	ulting in the underlying causa given in Part I.					23b. Did tobacco use contribute to the caus						
that that deta	<u>a</u>						101	08 212 NO	3 F10	Dably 4	Onkilo			
uires Ild be	2									24a. Was e	n eutopsy	24b. W	ere eutopsy	findings
w requ	<u> </u>									perfor	med?	CC	vailable prior of deeth?	causa
The law ate hes b page 2 si	Completed									124	es 2 No		□Yes 2□	7 No
iclan: The certificate rector, pag	25. Was case reterred to	medical						26 Place	of Doot			1	U 163 2L	3 140
Physician: this certific	examiner?	medical	Hospital:	patient 2 E	R/Outpatie	nt 3 DO	Oth	ner		h (Check only or ome 5 Resident		her (Sneci	6()	
Physician: The law requires the tribic confice to the confiltrate has been signed or director, page 2 should be				-	28b. Time o		Bc. Injur Wor		-	28d. Describe h			(y)	
ding P. After funer	1 Natural 5	Pending Investigation	28a. Date of I (Month,	Day Year)	Injury	М		rk? Yes 2 🗍	No					
l or Attending efter death. Director: After d in by the fune	3 Sulcide 6	2 Accident Investigation M 3 Sulcide 6 Could not be determined could not be determined 28e. Place of Injury. At home, farm, street, fa								28f. Location (S		ber or Rur	al Route Nun	nber,
or Attend efter death Director:	27. Manner of Death 1	dotommied	building	, etc. (Specify)						City or Tow	n, Stete)			
To the Hospital or within 24 hours efter To the Funeral Dirt completely filled in	29a. Cartifier 121		ysician: To the be											
he Hin 24 he Fi	one)	Medical Exar	niner: On the basi end menner		m ena/or in	vastigation,	in my c	pinion, das	un occuri	ed at tha tima, o	rata end piece,	ena aue t	o trie ceuse(2)
within 2 To the comple	29b. Signeture and title of	of certifier	, MD			29c.		se number			29d. Date sign			
		xBelo	m, MD	•			T	261	37		2:2	23.	1999	
	30. Name end address of	person who	complated cause	ot daath (Itam 2	23a) (Type	Brint)	ō +	± Inu		redon	م من	MA	2170	2
	198 Them	ios J	othnsor	Driv		suu	y 4	1109	. 1	o educa	, 1	- رلا ،	4110	12
Stat	e 31. Data filed (Month, Da	v. Year)	32. Reg	istrer's Signetu	ire	,								
Registra	r	EB 25	1999	Dener	~	Ø.	1	sack.	1					
HMH 16 Rev 6/95			,	0	- 1		17	-	2 - 0					



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	E OF MARYLAND / DEPART	MENT OF HEALTH AND N	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)	OLITIN I	OAIL OF BLAIT	2. DATE OF DEATH	3. TIME OF DEATH						
	Sister Bernadette O	Brien		Feb. 25, 19	YEAR						
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. lest birthdey)	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	99 7:35 P. M 8. BIRTHPLACE (State or Foreign						
	579-66-8298 1□M:	2 ∏ F 85 YRS.	MONTHS DAYS HOURS MIN.	Jan. 1, 191	Country)						
	9a. FACILITY NAME (If not institution, give street and nu		9b. CITY, TOWN OR LOCATION OF DE		COUNTY OF DEATH						
<u>ا</u>	Villa St. Michael		Emmitsburg		Frederick						
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY										
E E			TOWN OR LOCATION		10d. INSIDE CITY LIMITS?						
	Maryland Frederic	CK Emr	nitsburg		1 X YES 2 NO						
FUNERAL	333 South Seton Avenu		101. ZIP CODE	10g.	CITIZEN OF WHAT COUNTRY?						
N		DECEDENT EVER IN U.S. ARMED	21727	10 0010110 10 - 14 14 - 14	U.S.A.						
F	1 Never Married 2 Married FORC	ES? 1 YES 2 NO S. GIVE WAR OR DATES	If yes, specify Cuban, Maxicar	n, Puerto Rican, atc.)	Black, White, etc.						
ВУ	3 Widowed 4 Divorced	S, GIVE WAN ON DATES	1 YES 2 X NO Specify		Specify: White						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S U	ISUAL OCCUPATION ork done during most of working	16b. KIND OF BUSINESS	S/INDUSTRY						
	Elementary/Secondary (0-12) College	(1-4 or 5 +) life. Do NOT use	retired.)	Religious	Community						
MP		ege 5+ Account			of Charity						
ဗ	17. FATHER'S NAME (First, Middle, Last) John S. O'Brien			ME (First, Middle, Maiden Sumen	ne)						
BE	19a. INFORMANT'S NAME (Type/Print)			. Ryder							
5	Sister Camilla Harant		ADDRESS (Street and Number or Rural R								
	20a. METHOD OF DISPOSITION	20h PLACE AND DATE OF	Seton Ave., Em		N — City or Town, Stata						
	1V Burial 2 Cremation 3 Ramoval from:	State cemetery, cremetory or oth	er plecel		sburg, MD 21727						
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	St. Joseph	22. NAME AND ADDRESS OF FAC	MUTY CUTIES ELL	SDUTY, MU ZITZT						
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	les	210 W. MAIN ST	SKILES FU	C MD 21727						
	23. PANY I. Enter the diseases, or complicati	one that caused the death. Do no		•	-						
	ahock, or heart feliure. List only	one cause on each line.	to the mount of dying, add	· as calcied of respiratory	Interval Between						
	IMMÉDIATE CAUSE (Finel disease or condition										
	resulting in death)	DUE TO (DR AS A CONSEQUENCE OF)	Man	in a ca	Jacque						
z	disease or condition resulting in death) a. AD AT ON PILL MONICO A SACONSEQUENCE OF: DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
5	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF)	· Full								
CERTIFICATION	Cause. Enter UNDERLYING CAUSE (Disease or Injury		· · · · · · · · · · · · · · · · · · ·								
Ē	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF)	:								
CE	d										
AL	PART ii. Other eignificent conditions contribution	uting to deeth but not resulting in		Part I. 24s. WAS AN AUTOR PERFORMED?							
	- moral	421EU 172		1 YES 2 12 NO	COMPLETION OF CHIEF						
MEDIC	A hund Schola	30		_ ^ ^	1 - YES 2 - NO						
ä	03to Doras	3 ()									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	TAL:	26. PLACE OF DEATH (Che OTHER:	ick only one)							
YS		tlant 2 ER/Outpatlant 3 DOA	4 V Nursing Homa 5 Residence								
	27. MANNER OF DEATH 28a.	DATE OF INJURY (Month, Day, Year) 26b. TIME INJU	RY WORK?	28d. DESCRIBE HOW INJURY	OCCURED						
BY	2 Accident Investigation 3 Suicide a Could set by 26s.	PLACE OF INJURY — At home, farm, str	M 1 YES 2 NO	281. LOCATION (Street and Nu	onber or Grant Bouts Manha						
	4 Homicide 8 Could not be detarmined	building, atc. (Specify)	, tectory, office	City or Town, State)	moer or north Houte Number,						
	29a. CERTIFIER 1 [V] CERTIFYING PHYSICIAN: To the	a heat of my knowledge death economic			72013						
COMPLETED		e beat of my knowledge, death occurred page of examination and/or investigation									
	29b. SIGNATURE AND TITLE OF CERTIFIER	-	29c, LICENSE NUM								
98	R. EChhand	26 Detoi	De Huila	~ < /7	DATE SIGNED (Month, Day, Year) EER 26 1000						
2	SO MAME AND ADDRESS OF PERSON WHO COMPLE	TED CAUSE OF DEATH, (TEM 27) (Type	10 7 10 00	1171 101	FEB. 26, 1999						
	South O Bruch	PEC- PORTIE	197175	njus ejo	n Amual.						
	31. DATE FILED MANAGE TOOO 22. F	HEQUITRAN'S SIGNATURE									
	FEE 2 0 1999	perma B.	Aparts/								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 27 Year Robert R. Payne 9: 05 pm Februars 10,6,6, 4b. City, Town, or Location of Death-4a Facility Name (If not institution, give street and number) 4c. County of Deeth Washninster Canroll County (annol) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1⊠M 2□ F 219-20-3719 Dec. 26,1904 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Mt. Airy Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5950 Ridge Road 21771 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl T. Wolfe/ Nephew 4022 Gill Avenue, Hampstead, Maryland 21074 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Zion Lutheran Cemetery 3/3/1999 Middletown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 25 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to 24a. Was an eutopsy performed? completion of causa of death? 200 No 219 No 1 ☐ Yes 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Examiner à Attending Physician: 耆 Attac Division death. after death Director: To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

Physician/Medical þ Completed Certification: To

Physician

/Medical

Examiner

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Funeral

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Completed

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Funeral

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other than "naturel", or frams 23s or 28s-f showert, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filt Department of Health and Mentel Hy important: if Item 27 is marked oth any Injury or other traumatic event abos.

Physician /Medical

with the Maryland

altimore, Maryland 21215-0020

25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 S Natural

2 Accident

3 Suicide

4 | Homicide

5 Pending investigation 6 Could not be

28b. Time of

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, lerm, street, lectory, office building, etc. (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of confi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

adical

200 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 1 1999

nem. Ave, Westminster

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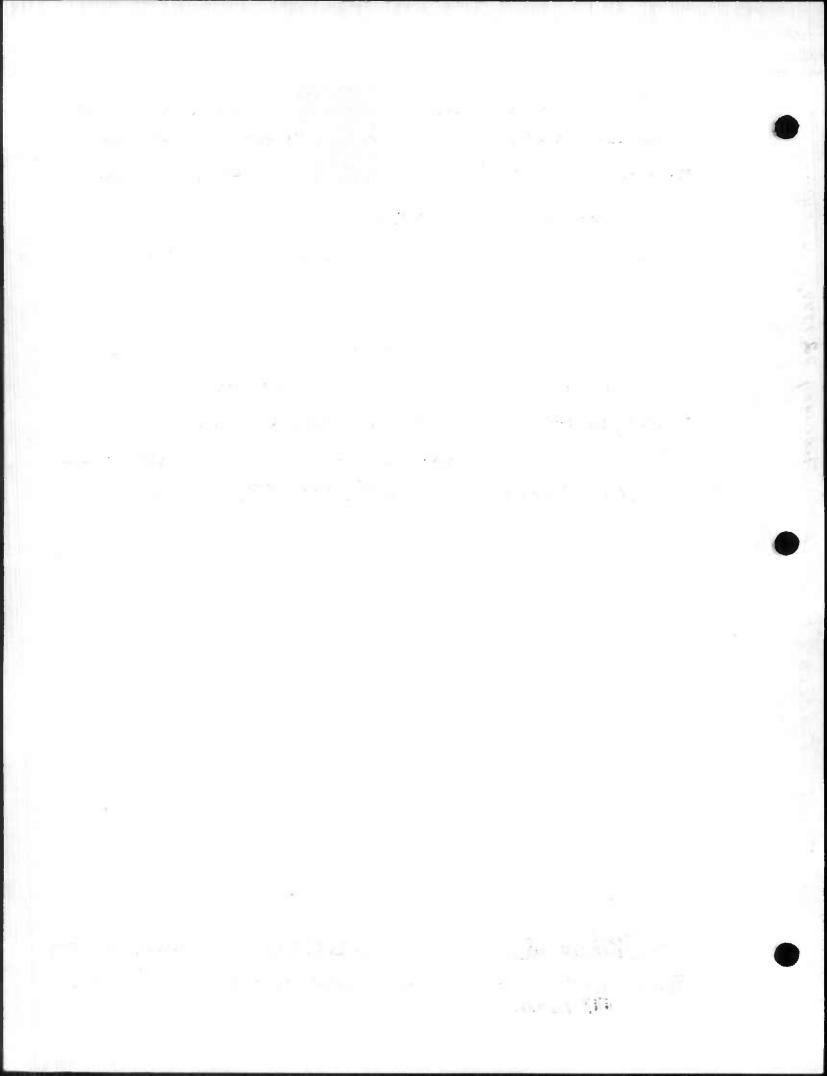
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Oi Waiyia		tificate of	Death	Re	g. No.	0	8019
	Physic /Medi		Decedent's Neme (First, Mid	Mary Franc		ese			2. Dete of Deet Month Feb. 22,	Dey	Yeer	3. Time of Death 6:25PM
	Examii	ner	4e. Fecility Neme (If not institute Willamsport N	_	number)		0	4b. City, Town, or Li Williamspo		4c. County Washi	of Deeth ngton	
	Funeral Director		5. Social Security Number 139–48–5664	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yr. 85	s. last birthdey) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey, Nov. 7,	Year) 1913	9. Birthpi Count Chic	ace (Stete or Foreign ry))
	how		Usuel Residence of Decedent 10e. Stete 10b. Coun		10c. C	ity, Town or Lo					10	d. Inside City Limits
	Se-f	Director		erick		Middle						1½ Yes 2 No
	th with the		10e. Street end Number 108 Locust Ct.				10f. Zip Code	1769	10	og. Citizen of V U.S.A		ry?
020	igas 1 and 2 should be filed within 72 hours aftar death with the Maryland it of Health and Mantal Hygiena. If Item 27 is marked other than "natural", or items 23a or 28e-f ahow or other traumatic event, the Marical Examinat must be noticed.	by Funeral	11. Maritel Stetus 1 ☐ Never Merried 2 ☐ Ma 3XX Widowed 4 ☐ Divorce	Armed f	2 X No Sive		Nes Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispenIc Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blec	- America k, White, e : Whit	etc.
21215-0020	e filed within 72 ho al Hygiena. other than "natur vent, the Medical	Completed		ent's Education est grade completed College	d) (1-4or 5+)	(Give	lent's Usuel Occup kind of work done DO NOT use retire METTAKET	during most of work	ring	6b. Kind of Bu	home	ustry
pu	be filed tal Hygie d other event, ti	Be	17. Fether's Neme (First, Middle					18. Mother's Nem		feiden Sumem	Θ)	
7	should be ind Mantal I marked or umetic eve	To	John Bu 19e. Informent's Neme/Reletion	twrinski		10b Maille	- Address (Chros	Agnes Bo		O'h T	Ct-t- 7/-	0-4-1
Ma	1 and 2 sho Haalth and em 27 is m		Frank G. Pugliese				-	end Number or Flur Rd., Boons		21713	State, Zip	C009)
Baltimore, Maryland	permit. Pagas 1 an Dapartmant of Haal Important: If Item 2 any Injury or other office.		20e. Method of Disposition 1 X Buriel 2 Cremetion 4 Donetion 5 Other	3 □Removel from	ii Stete	Plece of Dispo cemetery, cren	sition (Neme of netory or other ple emorial Par	ce)	Dete 2	octh Brun		
Balt	permit. Dapartn Importa any inju		21. Signeture of Funeral Service	Ourofo				ss of Fecility hampson Fun St., Middle		21769		
V	Physician	9.53	23e. Pert1. Enter the diseese, shock, or heert fellure. List	or complication that st only one cause on	caused the dec each line.							Approximate Interval Between Onset end Deeth
	/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting In death) Due to (or es e consequence of):									
	ν <i>≒</i>	iner			SPHAG		dence or):				1	WEEKS
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68/60 ,	ficata be axecuted physician and is tha bunal-transit	edical Examiner	thet initieted events	c. Mu	LTIPLE	CETZETS or es e consequ		FARCTS			'	YEAR'S
ROX PR			resulting in deeth) Lest	d								
	0 0 0	Physician/M	Pert II. Other eignificant condit	ions contributing to	death but not re	sulting In the ur	nderlying cause giv	ven in Pert I.	23b. Did to	becco use cor	tribute to	the cause of death?
т. О	as that tha de igned by the be datached	y Phy	RHEUMATOID	ARTHER	TIS				1 □ Ye	22(No	3 🗆 Prob	ably 4 Unknown
Hecords,	neguii een s hould	Completed by							24e. Wes er perform		con	re eutopsy findings lieble prior to opletion of cause leeth?
	The law rata has b page 2 s	Com							1□ Ye	s 2 XNo	1 🗆	Yes 2□ No
VITal	Physician: The this certificata iral director, par	o Be	25. Was case referred to medic exeminer?	Hospital:		∃ER/Outpatien	Oth	28. Place of Deet				
DIVISION OF	Attending Physic death. octor: Attar this by the funeral di		1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pend 2 Accident inves	28e. Dete	28c. Injui	Nursing Ho	ome 5 Reside 28d. Describe ho)		
DIVIS	To the Hospital or Attending Ph within 24 hours atten death. To the Funeral Director: Aftar th complataly filled in by tha funaral	Certification:	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify)							eet end Numbe , Stete)	er or Rural	Route Number,
	To the Hospital or within 24 hours afta To the Funeral Dir. complataly filled in	edicai	29a. Certifier 1 Certify (Check only one) 1 Medica	ng Physicien: To the Examiner: On the end me	e best of my kn basis of examin nner steted.	owledge, deeth etion end/or Inv	occurred at the tirestigation, in my o	me, dete end plece, plnion, deeth occur	end due to the ce red et the time, de	use(s) end me te end pleca, e	nner es ste and due to	eted. the ceuse(s)
	To the He within 24 To the Fu complete	Me	29b. Signeture end title of gertifi	er			29c. Licens	e number	29	d. Date signed	Month, E	Dey, Year)
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			30. Name and eddress of person			m 23a) (Type, I		IF RMI	sisoizo,	NI	71	7.7
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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Pick Madison Claire 1655 P February 1999 /Medical 4a. Facility Name (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Rockville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Shady Grove Adventist Hospital

5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Montgomery 6. Sex 1 ☐ M 2 ☐ F Social Security Number Birthplace (State or Foreign Country) **Funeral** Yrs. Director 2 Feb. 17, 1999 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Pagas 1 and 2 should be filed within 72 hours aftar daath with the Marylar nent of Health and Mantal Hygiena. snt: If item 27 is marked other than "natural", or fiems 23a or 28a-1 show ury or other traumatic event, the Medical Examinar munt to notified... 1√ Yes 2□ No Funeral Director Maryland Frederick 17 Norva Ave. 10f. Zip Code 10g. Citizen of What Country? 17 Norva Ave. USA 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ∆ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 21215-0020 1 ☐ Yes 2 TVNo Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highast grada completed) 16b. Kind of Bustness/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Child Child. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be Brian Tainter Pick Vida Lynne Penn 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Brian Pick, father 17 Norva Ave., Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Paga Department of Important: If any Injury or once. Smithsburg Crematory 2/22/99 Smithsburg, 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Servica Licanus 106 East Church Street, Frederick, MD 23a. Part1. Enter the disease, or complications that disease the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hold failure. List only one cause of such line. diger Approximete Interval Between Onset end Deeth **Physician** /Medical immediate Cause (Final . Intracranial 45min disease or condition resulting in death) Hemorchage **Examiner** 36 hrs sician and burial-transit Hypotensim be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Dua to (or as a consequenca of): P.O. Box 68760, Respiratory Failure
Dua to (er as a consequence of): Physician/Medical ro the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours affer death.

To the Funeral Director: Affer this cardificate has been completely filled in by the funeral process. 36 hrs Extreme Prematunty Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Respiratory Distress Syndrome: Be Completed by 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yas 2 ☐ No 25. Was case referred to medicat 26. Plece of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 3 Suicide 6 Could not be determined 28a. Placa of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stetad. Cal 29a. Certifier 29b. Signeture and title of certifier 29c. Licansa numbar 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) February 19, 1999 A. Kimberly Infolla, mo 9901 medical Center Drive Rockville, mo 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

Form, at the second included. parameter or section 25 years are an interest at magazine see see a file of the second the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Data of Death 3. Time of Deeth 1. Decedant's Nama (First, Middla, Last) Month Peggy Sue Padgett Feb 26, 1999 11:45 AM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital 5. Sociel Security Number If Undar 24 Hrs. 8. Dete of Birth Month Dev. Year 58 9. Birthplece (State or Foreign North) Carolina 7. Age (in yrs. last birthday) 6. Sex 1□ M 2√√ Months Deys Hours 261 35 9870 40 Yrs Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Charles Waldorf 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code United States 20601 10608 Mahogany Court 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yas, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien 11. Meritel Status Bleck, White, etc. 1 □ Naver Marriad 2 □ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Attorney Office Secretary 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Sarah J. Sweet Billy Jim Shadowen 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 10608 Mahogany Court, Waldorf, Maryland 20601 19e. Informent's Neme/Reletionship (Type, Print) Shelia Padgett (DAUGHTER) 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 \ Buriel 2 \ Cremetion 3 \ Removel from State 4 \ Donation 5 \ Other (Specify) Cedar Hill Cemetery March 1, 1999 Suitland, Maryland 22. Name end Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Faneral Service Licenses Alexandria Ferry Rd, Clinton, Maryland 20735 23a. Part. Effer the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, spock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death

Physician /Medical Examiner

ortant: If I

permit. Page Department of Important: If I any Injury or once.

Physician

/Medical

Examiner

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Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiena. Int: If Item 27 is marked other than "natural", or items 23e or 28a-f show ary or other treumatic event, the Magical Examination until be notified as

Baltimore, Maryland 21215-0020

physician and the burial-transit that the death certificate be axecuted USa signed by the at d be detached for paga 2 s has Hospital or Attending Physician:

Examiner

Physician/Medical

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Completed

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Certification: To

edicai

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) WAR 0 3

certificate funeral director, Aftar this aftar death.

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) reavs AlCohol Sequantially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Dua to (or as a consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Anemia proumonio 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? complation of causa of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes cese referred to medicel exeminer? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending 1 | Yes 2 | No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier (Check only one)

1999^{32.} Registra's Signeture

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Surratts Rd # 307. Clinton mD 20735 7501 Patch M.D

D46478

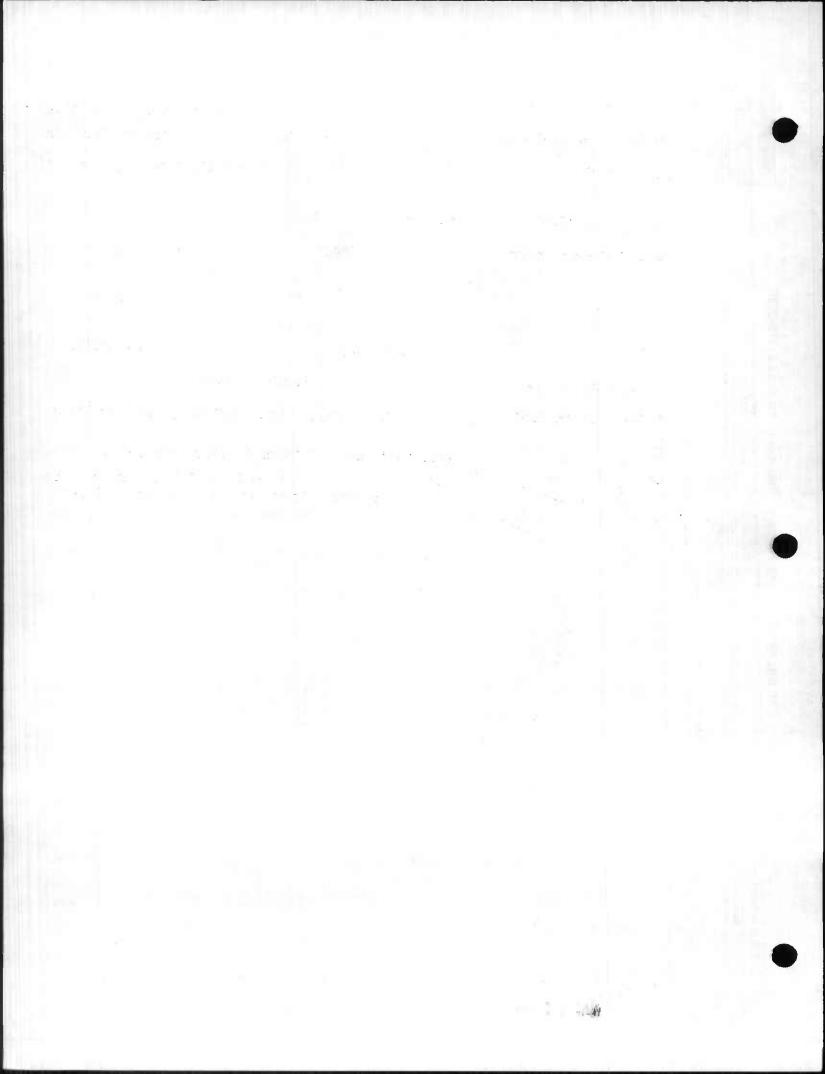
29c. Licansa number

29d. Date signed (Month, Dey, Year)

2.26.99

State Registrar

To the Hospital or Atterwithin 24 hours after der To the Funeral Directo completely filled in by the



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death

11:20 A.M.

		Certificate of Death		Reg. No.							
Physic /Medi		1. Decedent's Name (First, Middle, Last) Eloise Parran	2. Dete of De Month Februa	Dey	3. Time of Death 1999 11:20 A.M						
Exami		4e. Fecility Neme (If not institution, give street and number) Calvert County Nursing Center 4b. City, Town, or Prince F			,						
Funeral Director		5. Sociel Security Number 2.15-32-4410 6. Sex 1 Number 2.15-32-4410 7. Age (In yrs. lest birthdey) 8.7 Yrs. 8.7 Yrs. 1 Under 1 Year If Under 24 Hr Months Deys Hours Mir		rth 1911	9. Birthplece (State or Foreign Country) Maryland						
Meryland -1 show	tor	Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Maryland Calvert Prince Frederick			10d. Inside City Limits 1 ☐ Yes 2 ☐ No						
h with the 23a or 28a at be not	Funeral Director	10e. Street and Number 145 Arthur King Road 20678		10g. Citizen of USA	•						
DESIGNOTE, MISTYISING 21215-UU2U permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or Name 23a or 28a-1 show any Injury or other treumetic event, the Medical Examiner must be notified at ance.	by	11. Meritel Status 12. Wes Decedent Ever In U,S. Armed Forces? 1 Never Merried 2 Married 3 No if Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (If Yes, specify Cuban, Mexican, Pue) 1 Yes 2 No Specify:	Specify Yes or Norto Rican, etc.)		4c. County of Deeth Calvert 9. Birthplece (State or Foreign Maryland 10d. Inside City Limits 1 Yes 2 No 14. Rece - American Indian, Bleck, White, etc. Specify: Black 8b. Kind of Business/Industry Omeone else's home elden Sumeme) Howe City or Town, State, Zip Code) 7, MD 20678 11:20 A. 12:20 A. 14. Rece - American Indian, Bleck, White, etc. Specify: Black 8b. Kind of Business/Industry Omeone else's home elden Sumeme) Howe City or Town, State, Zip Code) The Code of the						
Mai yiaina 41215-0020 d 2 should be filed within 72 hours eff th end Mentel Hygiene. T is marked other than "naturel", or treumetic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupetion (Give kind of work done during most of work done) (Iffe. DO NOT use retired) Domestic	16b. KInd of Business/Industry Someone else's h								
Viana uld be filed Aentel Hyg rked othe tilc event,	To Be C	17. Fether's Neme (First, Middle, Last) Henry Parker Annie									
ind 2 shot alth end h		19e. Informent's Neme/Reletionship (Type, Print) Sarah Parker/Daughter 19b. Meiling Address (Street and Number or F. 0. Box 155 Prince)	Rural Route Numb Frederic	ber, City or Town	o, Stete, Zip Code) 20678						
Description of the supportant of the supportant: If Item 2 mportant: If Item 2 my Injury or other 100ce.	in to to the	20a. Method of Disposition 1	Dete 3/1/99								
permit. Departm Importa any Ink		21. Signature of Funeral Service Licansee 22. Name and Address of Facility Sewell Funeral Hollache a Sewell Funeral Hollache a Sewell Funeral Hollache a Sewell Funeral Hollache Beach Road Prince Frederick									
Physician /Medicai		23e. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardio shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ec or respiratory e	errest,	Intervel Between Onset and Deeth						
Examiner	Je.	resulting in deeth) e									
The law requires that the death certificate be executed ate hes been signed by the ettending physician end page 2 should be deteched for use as the burlal-trensit	ical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or es e consequence of):			5 month						
DOX OS eeth certifica ettending ph for use es ti	Physician/Medical	d									
that the dest		Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.		Yes 2 No	ontribute to the cause of death? 3 Probably 4 Unknown						
VICE THE law requires their certificate hes been signed i rector, page 2 should be det	Completed by		24e. Wes	s en eutopsy formed?	24b. Were eutopsy findings available prior to completion of cause of death?						
VICAL NE IN- Iclan: The law certificate hes rector, page 2	0	25. Wes case referred to medical 26. Place of Dr		Yes 2 No	1 Yes 2 No						
yalclan: s certific director,	O B	examiner?	eeth (Check only Home 5 Res		her (Specify)						

3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be Co 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Neturei 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) end menner stated. 29e. Certifier

29b. Signeture end title of certified

31. Dete filed (Month,

29c. License number 29d. Date signed (Month, Day, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Charles Judge,

Registrar's Signeture

Prince Frederick, MD

Feb. 24, 1999

State Registrar

D29657

To the Hospital or Attending Physician: "within 24 hours effer deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

Division of Vital

A F 18 man . .

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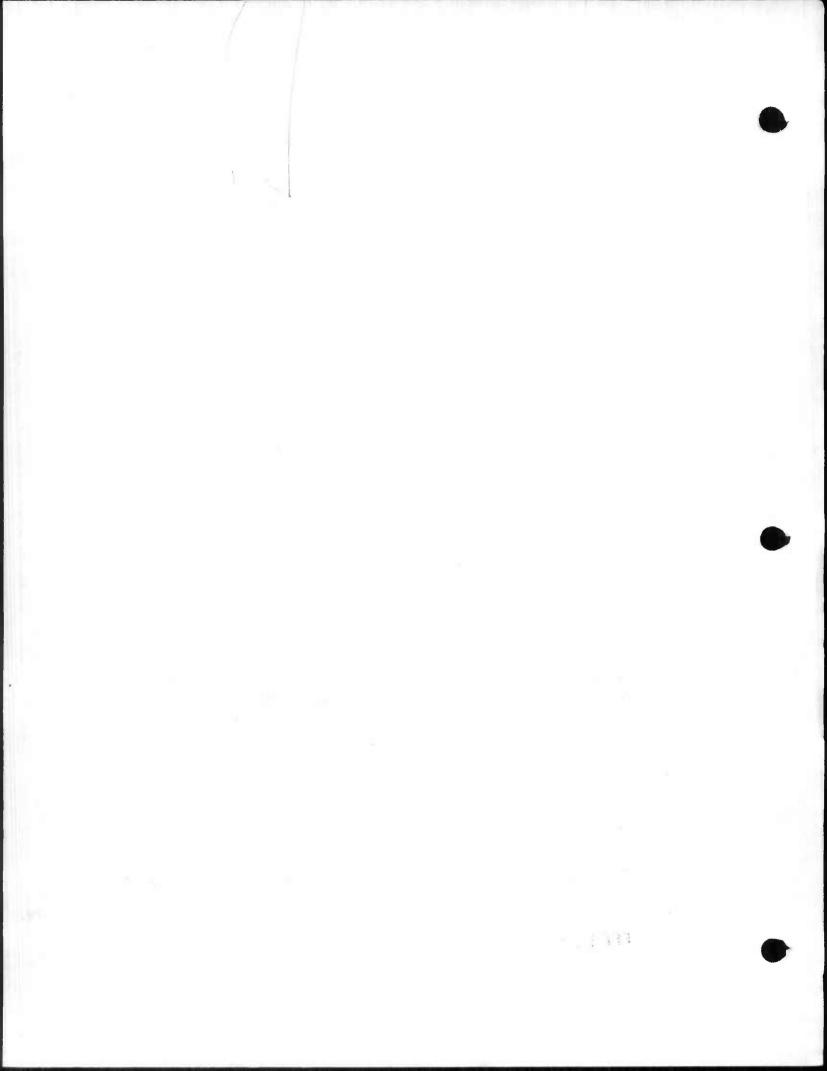
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. KBALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

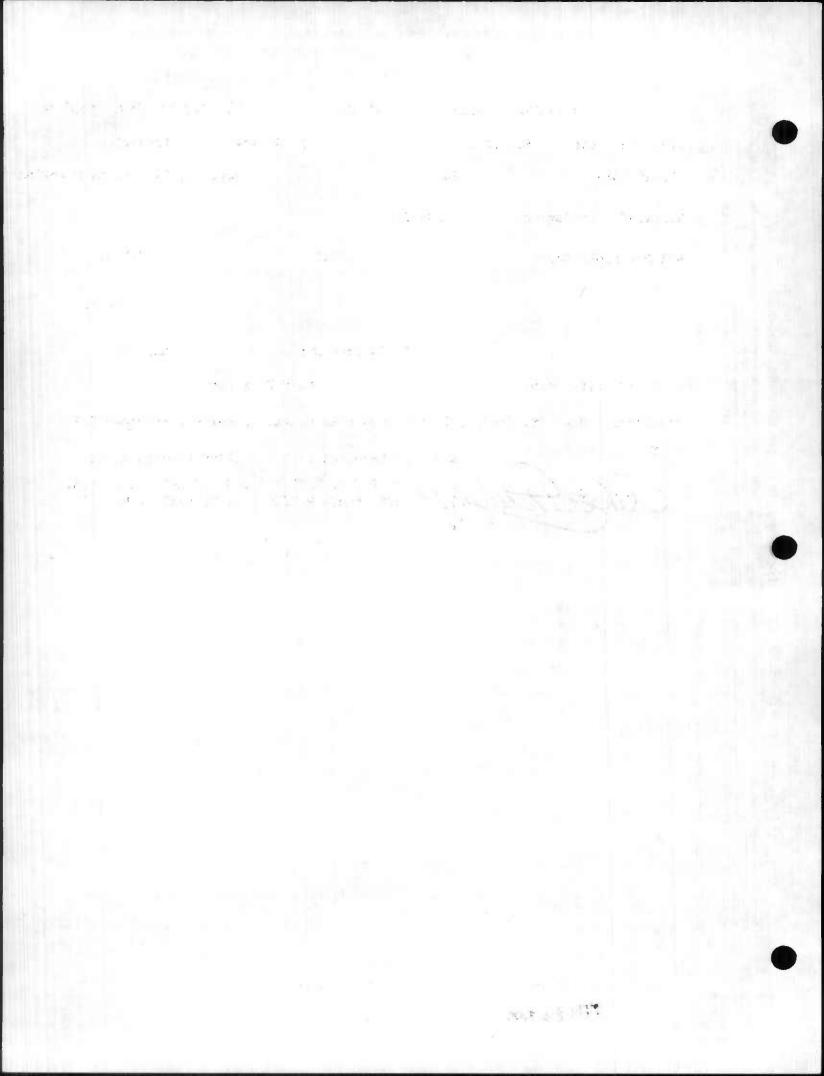
REGISTRAR CERTIFICATE OF DEATH REG. NO.													
	1. DECEDENT'S NAME (First, Middle, Last) Dorothy	Irene	Raffte	saeth					2. DATE OF DEATH MONTH DA		YEAR	3. TIME OF DEATH 5:20 a. M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la			man I		_		23 19			
	193-36-3473	1 □ M 2 🂢 F	93	YRS.	MONTHS I	DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year) May 28, 19	905		PLACE (State or Foreign ry) Sylvania	
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, T	OWN O	R LOCATIO				UNTY OF D		
OR	Frederick Health	Care Cen	ter		Fred	eri	.ck				deric		
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v		1 20 0	10c. CITY, TOWN OR LOCATION 10d								
DIRECTOR	Pennsylvania Daur				arris					10d. INSIDE CITY LIMITS? 11 YES 2 NO			
	10e. STREET AND NUMBER											71	
FUNERAL	2455 Berryhill St	reet				101. ZIP CODE 17104					10g. CITIZEN OF WHAT COUNTRY? USA		
5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. A	RMED	13. WA	S DECE	ENDENT O	F HISPANI	C ORIGIN? (Specify Yes	or No-	14. BACI	E — American Indian	
	1 Never Married 2 Married	FORCES? 1		NO	lf y	es, spe	cify Cuber	n, Mexican	, Puerto Rican, etc.)		Black	E — American Indian, k, White, etc.	
B√	3 🔯 Widowed 4 🗌 Divorced		III OII DAI ES		1 ''] TES	2 X NO	эреспу.			Speci	"" White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a, DI	ECEDENT'S	USUAL OCC	UPATIO	N of weeking		16b. KIND OF BUS	INESS/IN	DUSTRY		
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5 +	iife	. Do NOT us	vork done dur ne retired.)	my mos	or working						
P	11		Но	mema	ker				Own H	ome			
🛭	17. FATHER'S NAME (First, Middle, Lest)								NE (First, Middle, Maiden	Sumame)			
띪	Menno Light								lorst				
2	19e. INFORMANT'S NAME (Type/Print)		1						oute Number, City or Town				
	Alice Tritt					1.000		/ille	e, Marylan				
	20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ram	oval from State	20b.PLACE cerpetecy, cri	AND DATE (OF DISPOSITI	ON (Nan	me of	0	1		- City or To		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	FNSFF	urrr	Churc		_	D ADDRES			Leona	a, PA	1	
	() 0.1	2 -							50			treet	
	with I of	referte		Ricketts Funeral Home Myersvi								, MD 21773	
	23. PART I. Enter the diseases, or a shock, or heart failure.	complications that	caused tha de	eath. Do r	ot entar th	a mod	la of dyli	ng, such	as cardiac or reapi	ratory sr	reat,	Approximate	
	IMMEDIATE CAUSE (Final	Liet Only One Ced:	e on auch int		•							Interval Between Onset and Death	
	disease or condition resulting in death)	a. F	tupo	ens	MIL							Herry	
		DUE TO (110	QUENCE O	,		-	_			No. C		
NO NO	Sequentially list conditions,	b	OR AS A CONSE	ngia	me	0	Det	hy			years		
ATI	If any, leading to immediata cause. Enter UNDERLYING	DOE TO (OH AS A CONSE	QUENCE OF	1		D =	7					
윤	CAUSE (Disease or Injury that Initisted events	c	OR AS A CONSE	DUENCE OF	100 M	210						years	
Ē	resulting in dasth) LAST			Johnson or	,.							i '	
CERTIFICATION		d											
AP.	PART II. Other significant condition										24b	WERE AUTOPSY FINDINGS	
EDICAL	Recent Hip Fr	tibuille	ation	Neu	NON	ses	+	4	1 TES 2	. /		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
	Recent HiD FV	active:	SINOE	er Re	Juch 1	T	nter	notF	ivetur	7		OF DEATH?	
Z	DID TOBACCO USE CONTI	RIBUTE TO CAL	JSE OF DEA	TH YE	SIN	оΠ	UNC	ERTAIN	X				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				H (Check only	_	0110		A				
Sic	EXAMINER?	HOSPITAL: 1 Inpatient 2	FR/Outpatient 3	□ noa	OTHER:	. Nama	c 🗆 0						
Ŧ	27. MANNER OF DEATH	28e. DATE OF		26b. TIM		ic. INJU			28d. DESCRIBE HOW IN	LIUSY OC	CUBED		
	1 Natural 5 Pending	(Month, Da	y, Year)	INJ	URY	WOR	K? ES 2		Eve. DECOMBE HOW II		COMED		
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At he	ome, ferm, s					28f. LOCATION (Street a	nd Numbe	e or Rural F	Inute Number	
COMPLETED	4 Homicide determined	building, e	rtc. (Specify)						City or Town, State)			Notes in the state of the state	
=	290. CERTIFIER 15 CERTIFYING PHYSI	CIAN: To the heat of	mi knowledne de	odb assum	d at the stee	4.4	Ca latti		o the cause(a) and man				
₹ I	(Check only one) 2 MEDICAL EXAMINE											and manner or stated	
	298. SHORAPURE AND TITLE OF CERTIFIES					_							
H	1 May July	Mn					29c. LICE	NSE NUME	BER	29d. DAT	E SIGNED	(Month, Day, Year)	
2	38. NAME AND ADDRESS OF PERSON WHO	14/1	F OF BETT!	14.07. ~	D: 0		10	T 13	30	-4	471	ון	
	The state of the s	OHNSCN I	UP IS			L -	TOLL	MCCIA I	Davie	FRE	ne.e	ctr. MD 21702	
	31. DATE FILED (Month, Day, Year)	32 REGISTRAS	'S SIGNATURE	0 1 1	1010	170	10 11	الحداد	PICME	1 100	ULYL	2.10	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Lest) **Physician** February Riddel 23 1999 Florence 6:32 AM Splude /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Frederick Memorial Hospital Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F Yrs. **Director** 239-20-9384 74 Aug. 26, 1924 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. tnside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Maryland Frederick 1 X Yes 2 No Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 822 Dunbrooke Court 21701 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas ≥ ☑ No If Yes, Give Yaar or Dates: 14. Race - American Indian. Was Decedant of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 🔀 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) College (1-4or 5+) 5+ Elementery/Secondary (0-12) Registered Nurse Nursing 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middla, Last) Tolliver Clyde Splude Mary Barringer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Alexander Riddel Jr. (Husband) 822 Dunbrooke Court, Frederick, Maryland 21701 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removal from State Randolph Memorial Park 2/27/99 Randleman, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Fu ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 th. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physicien and the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequenca of): USB for Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by that 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy paga 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificata Division of Vital Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Sinpatient 2 ER/Outpatient 3 DOA this funarai 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Hospital or Attending 24 hours after death. 1 Natural 1 Yes Investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 ☐ Homleide To the Hospital within 24 hours a To the Funeral Complately filled Certifying Phyatotan: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.

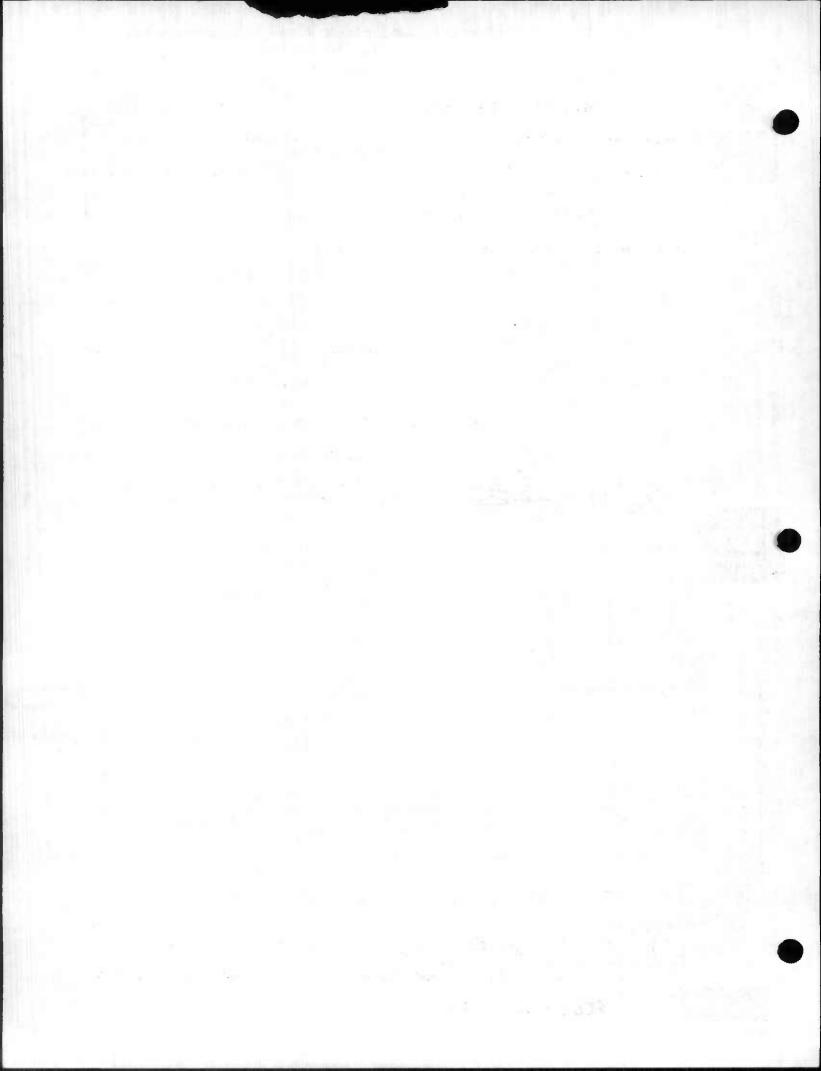
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. Licansa number D21648 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 9th street Relevel MD = 1701 BARAKAT KUSAY 810 w 31. Date filed (Month. 32. Registrar's Signature State B. Sparker

Registrar



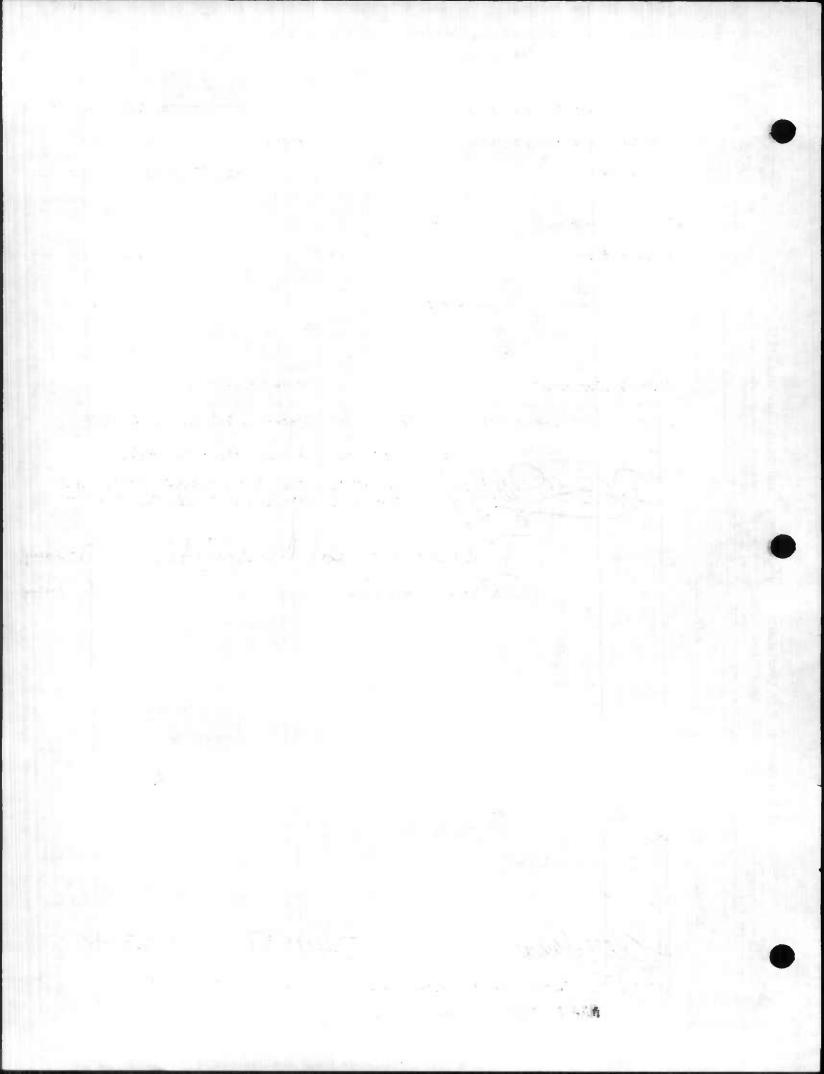
State of Maryland / Department of Health and Mental Hygiene

Physici		Decedent's Neme (First, Middle, Last)	Cer	tificate of	Dealii	2. Dete of Dear	eg. No.	- 1	3. Time of Daat	
		MARGARET LITTLE	RTRTF			Month Februa:	Dey	Yeer L999	1:45 PM	
/Medic Examir		4e. Fecility Neme (If not institution, give street and number)	KIKID		4b. City, Town, or Lo		4c. County of			
		1001 Carroll Parkway #211			Frederic	k	Frede	erick		
Funeral Director		177-18-7173 1□M 21XF	(In yrs. lest birthday) 79 Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 3	Year) 1919	9. Birthple Count Scot	ece (Stete or Ford Land	
*		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	eation				10	id Inelda City Lie	
28a-f show	ctor	Maryland Frederick	Frederick					1		
23a or 2	Funeral Director	100. Straet end Number 1001 Carroll Parkway #211		10f. Zip Coda 2170)1	1	*		ry?	
thyliene. thyliene. the Madical Examiner must be notified at	É	11. Maritel Stetus 1 □ Naver Married 2 □ Married 3 ☑ Widowed 4 □ Divorcad 12. Wes Decedent Examed Forces? 1 □ Yes 2 □ No If Yes, Give Yeer or Detes:	o If	/as Decedent of H Yes, specify Cub ☐ Yes 2 (No	tispenic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		, White, e	tc.	
ntal Hygiene. d other than "natu	Completed	15. Decedent's Education (Specify only highest grede completed) Elamantary/Secondary (0-12) Collega (1-4or 5+	-)	ent's Usuel Occup kind of work done O NOT use retired Iomemaker	eation during most of workin d)	99		iness/Indi	ustry	
d d	To Be C	17. Father's Neme (First, Middle, Last) Walter Little			18. Mother's Neme Mary McQ		Meiden Surname)		
end Men is marke aumatic		19e. informant's Neme/Relationship (Type, Print)	19b. Mailing	Address (Street	and Number or Rura	Route Number	City or Town, S	Stete, Zip (Code)	
Item 27 other tr		John H. Tisdale (Son-in-law 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removel from State	Dete	20c. Location - C	City or Tov	m, State				
Department of Important: If any Injury or anse.		4 Donetion 5 Other (Specify) 21. Signature of Euneral Service Densee			ss of Fecility		-		_	
OE S N		Lults 1 State	12	O1 NORTH	I MARKET O	T FRE	FREDERICK MD 21701			
	Physician/Medical Examiner	if eny, leading to Immediate cause. Enter Underlying Couse (Disease or injury that initiated quarter.	ue to (or es e consequ							
ettending for use e	an/M	d					eer, City or Town, State, Zip Code) ederick, MD 21702 20c. Location - City or Town, State Ft. Myer, Virginia NERAL HOMES, P.A. EDERICK, MD 21701 Approximate Intaval Batween Onset end Death			
ed fo	hysic	Pert II. Other eignificant conditions contributing to death but	derlying cause giv	en in Pert I.	23b. Dld to	bacco use cont	ribute to	the cause of de		
d by the	-		10////	10 000	monne		2□ No :			
igne be d	by	Hypertersum, Chro.	rie Obst	uctive	zulanna Zulanna		n eutopsy	24b. War	e eutopsy findin	
ate hes been signer pege 2 should be d		Hyperterson, Chro.	rie Obst vis	uctive	julana		n eutopsy ned?	24b. War evei com of de	e eutopsy findin leble prior to pletion of cause seth?	
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his certificate hes been signer al director, pege 2 should be d	To Be Completed by	exeminar? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA Oth	26. Plece of Deeth er: 4□ Nursing Hom	24a. Wes er perform 1 Ye (Check only one	Specity: White 16b. Kind of Business/Industry Own Home Meiden Sumame) or, City or Town, Stete, Zip Code) ederick, MD 21702 20c. Location - City or Town, State Ft. Myer, Virginia NERAL HOMES, P.A. EDERICK, MD 21701 rast, Approximate intaval Batween Onset end Death Onset end Death Obacco wee contribute to the cause of death? ee 2 No 3 Probably 4 Unknown on eutopsy med? 24b. Ware eutopsy findings eveileble prior to completion of cause of deeth? es 2 No 1 Yas 2 No na) anca 6 Other (Specify) ow injury occurred			
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in 24 hours efter death. The Funeral Director: After this certificate hes been signer pletely filled in by the funeral director, page 2 should be d	Medical Certification: To Be Completed by	exeminar? Yes 2 No	2 ER/Outpatient 28b. Time of Injury y - At home, farm, stree (Specify) my knowledge, daeth oxemination end/or Invad.	3 DOA Oth 28c. Injun Worl M 1 1 et, factory, office cocurred et the tim stigation, in my of	26. Plece of Deeth er: 4 \(\text{Nursing Hom} \) \(\text{y et} \) \(\text{Yes} \) 2 \(\text{No} \) \(\text{No} \) \(\text{1.5} \) \(24a. Wes er perform 1 Ye (Check only one e 5 Resida Bd. Describa ho Bf. Location (Str. City or Town	s 2-1 No a a a b ca 6 Other w injury occurre ceet and Number s State) use(s) end manual teend plece, en	24b. War evel com of de 1	e eutopsy findinieble prior to pletion of cause seth? Yas 2 No Route Number, ted. the cause(s)	



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3 Time of Death Month **Physician** 28, STANLEY THOMAS SIMONDS February 1999 9:52 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Nema (If not institution, give street and number) 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6. Sex 1 M 2 □ F If Under 1 Yaar 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months Days Yrs. 159-36-1332 83 29, 1915 Director Dec. Pennsylvania Usuel Residence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is merked other than "natural", or flems 28a or 28a-f show other treumstic event, the Medical Examinar must be notified at 1 No Yes 2 No Director Larksville Luzerene 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 67 West First permit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a empi injury or other treumatic event, the Medical Expraner means 000. 18651 U.S.A. Funeral 12. Was Decedent Ever in U,S. Amed Forcas? 1 ☑ Yas 2 ☐ No If Yes, Give Yaar or Datas: Korean Was Decedent of Hispenic Origin? (Specify Yas or No if Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritai Status Bleck, White, etc. 1 Never Merriad 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highast grada completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Teacher Teaching 17. Fethar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Michael Simonovich Mary Karmilovich 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Elaine Jaradat (Daughter) 2206 Deerfern Crescent, Baltimore, MD 21209 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cramation 3 Ramoval from Stata Peter & St. Paul Cem. 3/5/99 Plymouth, PA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signature of Fu 1201 NORTH MARKET ST., FREDERICK, MD 21701 e deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, Pert1. Enter the discount complice that a year shock, or heart failure. List only one challe on each light Approximeta tntarvel Between Onset and Deeth **Physician** Immediete Cause (Final disease or condition resulting in daeth) /Medical Examiner Dua to (or as a consequence of): Examiner 2) nome ician and burial-transit certificate be axecuted Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Cause (Disaase or Injury thet Initiated evants resulting in deeth) Lest Due to (or es e consequence of): physician s the burial Box 68760. Physiclan/Medical Dua to (or as e consequence of) USB BS ed by the attending I detached for use as 23b. Did tobecco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t d be detact 20 No 3 Probably 4 Unknown 1 Yes þ 24a. Wes en autopsy performed? 24b. Wera eutopsy findings aveileble prior to Completed peeu completion of causa of daeth? has No No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical exeminer? Be 26. Piace of Death (Check only one) 1 ☐ Yas 2 No Hospitel: Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Inpatient 2 2 ER/Outpetient 3 DOA funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. injury et Work? Certification: Natural 5 Panding investigation death. 1 ☐ Yes 2 ☐ No 2 Accidant or Attend aftar death Director: 6 Could not be datarmined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, streat, factory, offica building, atc. (Specify) 4 Homicida 24 hours a 29a. Certifier (Check only one) 🚈 Certifying Physician: To the bast of my knowledga, daath occurred at tha tima, data and place, and due to the ceusa(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end mannar stated. To the Vithin 2 29b. Signature and title of certifie 29d. Dete signed (Month, Day, Year) 29c. Licansa number 30. Name and address of person who completed causa of deeth (Itam 23e) (Type, Print) William H. Johnson, MD 187 Thomas Johnson Drive, Frederick, MD 21701 31. Dete filed (Month, Day, 32. Registrar's Signature Yeer) State MAR 0 1 1999

Registrar

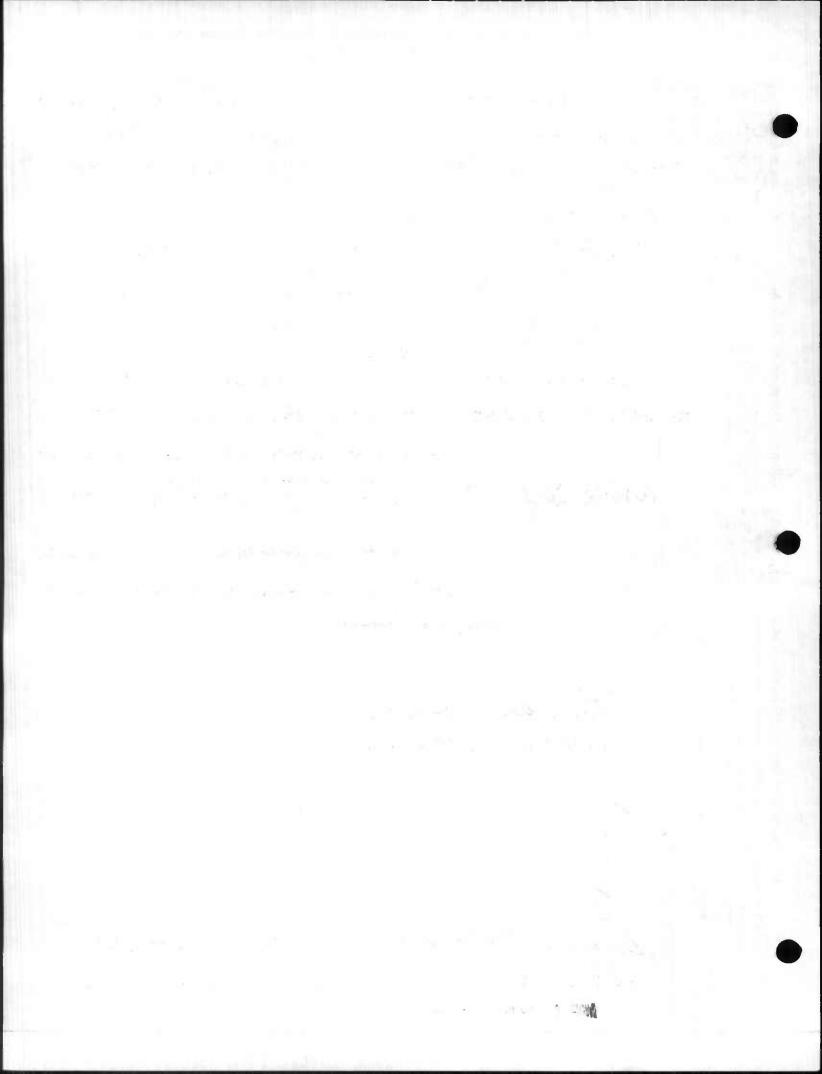


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death February 28, 1999 **Physician** Anna Elmira SMITH 12:10 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Northampton Manor Nursing Home Frederick Frederick 5. Sociel Security Number If Under 1 Year If Unger 2 Hrs. 8. Dete of Birth Sept. 16, 1901 Mary Land 7. Age (In yrs. last birthdey) **Funeral** 1 M 2 V F Hours 214-10-4685 97 Yrs. Director Usuel Residence of Decedent deeth with the Maryland 10a Stete 10h Counts 10c. City, Town or Location 10d. fnside City Limits r than "natural", or items 23s or 28s-1 show Frederick Maryland Frederick 1X Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 241 Wyngate Drive 21701 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 25 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker i. Peges 1 and 2 should be filed w tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other treumatic event, Ital Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Lydia Gertrude SUMMERS Danie1 Luther FISHER 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Bernard L. Wiles, Sr., Nephew 2315 Baltimore Pike, Gettysburg, Pa. 20b. Plece of Disposition (Name of cametery, crametory or other plece)

Mount Olivet Cemetery, March 3, 1999 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 □ Cremetion 3 □ Removel from State Department of Important: If eny Injury or Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last of Vital Records. P.O. Box 68760. Oue to (or as a consequence of) for use es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy tindings eveileble prior to completion of cause of deeth? pege 2 should Completed 24a. Wes en eutopsy performed? 1□Yes 2☑No 1 Yes 2 No tal or Attending Physicien: The ster death.

al Director: After this certificeit ied in by the funeral director, pr Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 1 Neturel 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital within 24 hours e To the Funeral C Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piace, end due to the ceuse(s) end menner es steted.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) end menner stated. Medical 29a. Certifier completely (Check only 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) miller of D March 1, 1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Ronald E. Miller, MD, 4 Culwell Drive, Mount Airy, MD 21771 32. Registrer's Signeture AR 0 2 1999 > Registrar



State of Maryland / Department of Health and Mental Hygiene

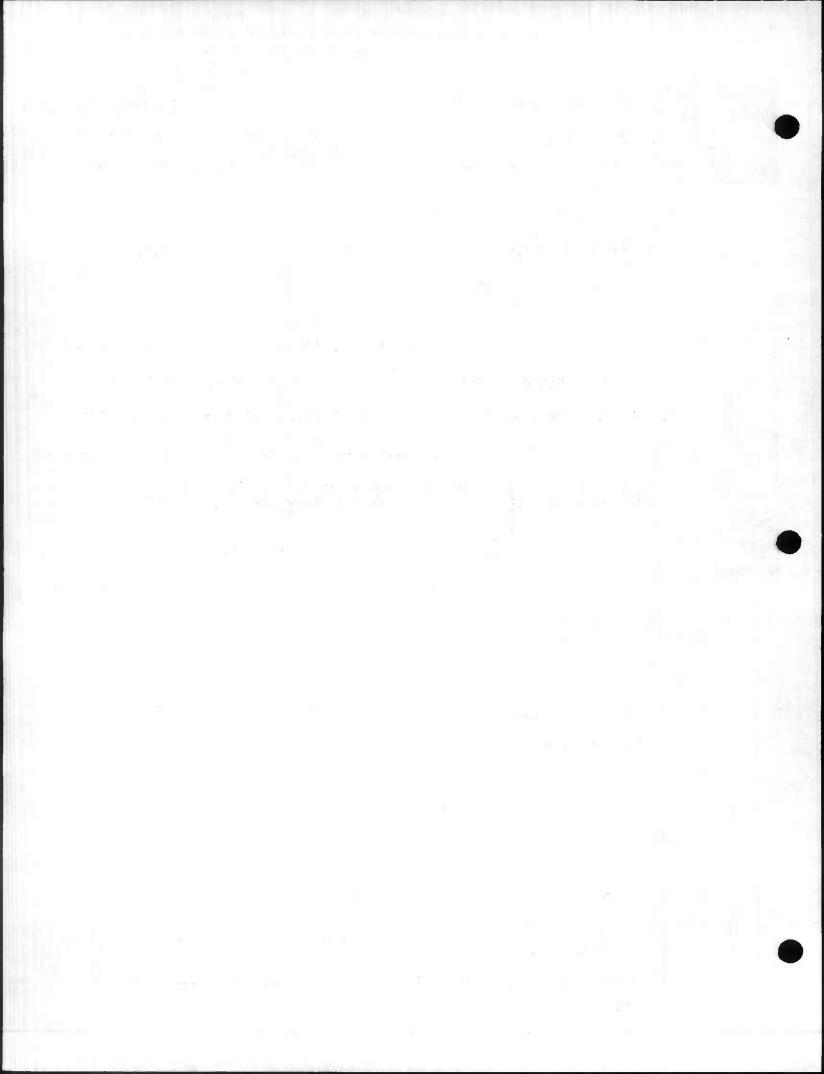
				Otate of Mary		Certificate o		-	Reg. No.) ()	8028
	Physic	ian	1. Decedent's Neme (First, Middle, Las					2. Dete of De Month		Yeer	3. Time of Deeth
4	/Medi		James	Howard		STUNKLE		Febuary		999	3:45 am
	Examii	ner	4e. Fecility Neme (If not institution, give Glade Valley Nurs		ilita	tion Ctr	4b. City, Town, or Walkers		111111111111111111111111111111111111111	of Deeth deric	l _e
	Funeral Director		5. Sociel Security Number 6. Se 705-07-7615			nday) If Under 1 Yes	ar If Under 24 Hrs	8. Dete of Bir			ece (State or Foreign
	anyland	2	Usual Residence of Decedent 10e. Stete 10b. County Maryland Freder		City, Town	or Location mitsburg				100	d. Inside City Limits
	with the N Se or 28a-f	i Directo	10e. Street end Number 15341 Sixes Road			10f. Zip Code	21727	,	10g. Citizen of W	Whet Countr	
020	a within 72 hours efter death with the Maryland ilene. Then "natural", or flems 23a or 28a-f show the Medical Exemine must be nutified at	Completed by Funeral Director	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes:	n U,S.	13. Was Decedent of If Yes, specify Cu		Specify Yes or No to Rican, etc.)		e - Americar k, White, et	
21215-0020	S 2	npieted	15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12)	cation de completed) College (1-4or 5+)	16e. I	Decedent's Usuel Occ 'Give kind of work don life. DO NOT use reti ack Forema	upetion le during most of wo red)	rking	16b. Kind of Bu		istry
d 2	il Hygiene. other than		17. Fether's Name (First, Middle, Last)			der rozema		me (First, Middle,			
lan	of la b	To Be	Frederick	E		STUNKLE		. Maideil Sumem	FR	YE	
Maryland	1 and 2 should be Health and Mental em 27 is marked of other traumatic eve	_	19e. Informent's Name/Reletionship (7) James E. Stunkle		19b. 96	Meiling Address (Stre 20 Harvest	et and Number or R Knolls W	ural Route Numbel	er, City or Town, Chersbur	Stete, Zip C	20882
Baltimore,			20e. Method of Disposition 13☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	Temover from State	b. Pleca of l cemetery [t Oli	Disposition (Name of a cremetory or other power Cemete	ry Mar 2,	Dete 1999	20c. Location - Frede		m, State Maryland
Balt	permit. Pages Department of Important: If Is any Injury or ance.		21. Signature/of Funeral Service Voens		0706		Basford				yland 2170
	Physician		23e. Pert1. Enter the disease, or compl shock, or heart feilure. List only of	lications that caused the dine ceuse on each line.	leath. Do no	ot enter the mode of d	ylng, such es cardie	c or respiratory e	mest,	1	Approximete Intervel Between Onset end Deeth
	/Medicai Examiner	L	Immediate Ceuse (Finel disease or condition resulting in deeth)	e. Whe	o (or es e co	onsequenca of):	slass				yeors
	secuted and al-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate	b. Due to	o (or es e co	onsequence of):					
68760,	rificete be executed ig physician and es the buriel-trensit	edical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury the initiated events resulting In death) Lest	Due to	o (or es e co	nsequence of):					
Box	ndir use	Physician/M		d							
	the death ce y the attendia	sicia	Pert ii. Other significent conditions con	ntributing to death but not	resulting In	the underlying cause	given In Pert I.	23b. Did	tobacco uee con	tribute to t	the cause of death?
s, P.O	es that the death igned by the atte be deteched for	by Phy	anemis					1 🗆	Yes 212 No	3 ☐ Proba	ably 4 Unknown
Record	v require been s should	Completed I							en eutopsy rmed?	eveil	re eutopsy findings ileble prior to apletion of cause eeth?
Ä	iclen: The law certificate hes b rector, page 2 s	Com						10	res 20 No	10	Yes 2□ No
of Vital	Physician: this certific ral director,	Be	25. Wes case referred to medical examiner?	doenite la				eth (Check only o	one)		
	Phys	lon: To	27. Menner of Deeth 1 Naturel 5 Pending	dospital: 1 ☐ Inpatient 2 28e. Dete of Injury (Month, Dey Yeer	2 ER/Outp 28b. Tin	me of 28c. In		dome 5 Resident	denca 6 Other		
Division	or Attending after death. Director: Afte In by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - A building, etc. (Spe	it home, farr		HISCH TO	28f. Location (S City or Tox	Street end Numbern, Stete)	er or Rural I	Route Number,
Ī	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29e. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	elcian: To the best of my kiner: On the besis of exam and manner steted.	knowledge, inetion end/	deeth occurred et the or Investigation, In my	time, date end pleca opinion, deeth occu	a, end due to the urred et the time,	cause(s) end me date end plece, e	nner es ste and due to t	ited. the cause(s)
	Within To the	Me	29b. Signeture and title of cartifier			29c. Lice	nse number		29d. Dete signed	1 (Month, D	ey, Year)
			Auson			T,D	26516		MARC	HI	1999
			30 Name and eddress of person who co	empleted cause of deeth (I	Item 23e) (T	TANET A	Je Fa	LED N	¥ 71	170	2
	Sta Registr		31. Dete filed (Month, Day, Year) WAR 0 2	32. Registrers Sig	gneture	4	6				

and the second

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 25, 1999 Helen Virginia SHREVE 7:50 AM February /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Frederick Frederick Frederick Memorial Hospital | Months | Deys | Hours | Min. | Nov - 2, 1914 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2XF 217-10-9102 84 Maryland Yrs Director Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumetic event, the Medical Examiner must be notified at Maryland Frederick Frederick No 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 250 East Seventh Street U.S.A. 21701 items 23a Funeral 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. parmit. Pages 1 and 2 should be filed within 72 hours effer of Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or free limportant: If Item 27 is marked other than "naturel", or free any injury or other traumatic event, the Medical Examines and. 1 ☐ Yes Ž\No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Presser/ Seamstress Clothing Factory 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) **Ulysses** Grant KEENEY Daisy Edward 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. John T. Hildebrand, Son 104 Linden Blvd., Middletown, Maryland 21769 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20c. Location - City or Town, Stete Mount Olivet Cemetery, Feb. 27, 1999 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Keeney and Basford P.A. Funeral Home M00255 23a. Pert1. Enter the disease, or complications het caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 21701 Approximete Intervel Between **Physician** Heart Failure /Medicai Immediete Ceuse (Finel diseese or condition resulting in death) **Examiner** Examiner SIO The lew requires that the death certificate be axecuted -transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest and physicien a s the burial-1 P.O. Box 68760, Physician/Medical the Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by cerebrovasalor 1 Yes 2 No 3 Probably 4 Unknown acc, Records, þ Be Completed 24b. Were autopsy findings eveilable prior to 24e. Wes en eutopsy atrial Fibrillation completion of cause of death? page 2 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: '24 hours after death.'
Funeral Director: After this certificatiety filled in by the funeral director, g 25. Was cese referred to medicel exeminer? 26. Piece of Deeth (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ FR/Outpetient 3 ☐ DOA edical Certification: To 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Neturel 5 Pending 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral D
complately filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29a. Certifier the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) February 25, 1999 D 09689 30. Name end eddress of person who completed cause of deet (Item 23e) (Type, Print) A. Austin Pearre, Jr., M.D., 300 West Ninth Street, Frederick, MD 31. Date filed (Mor State Registrar



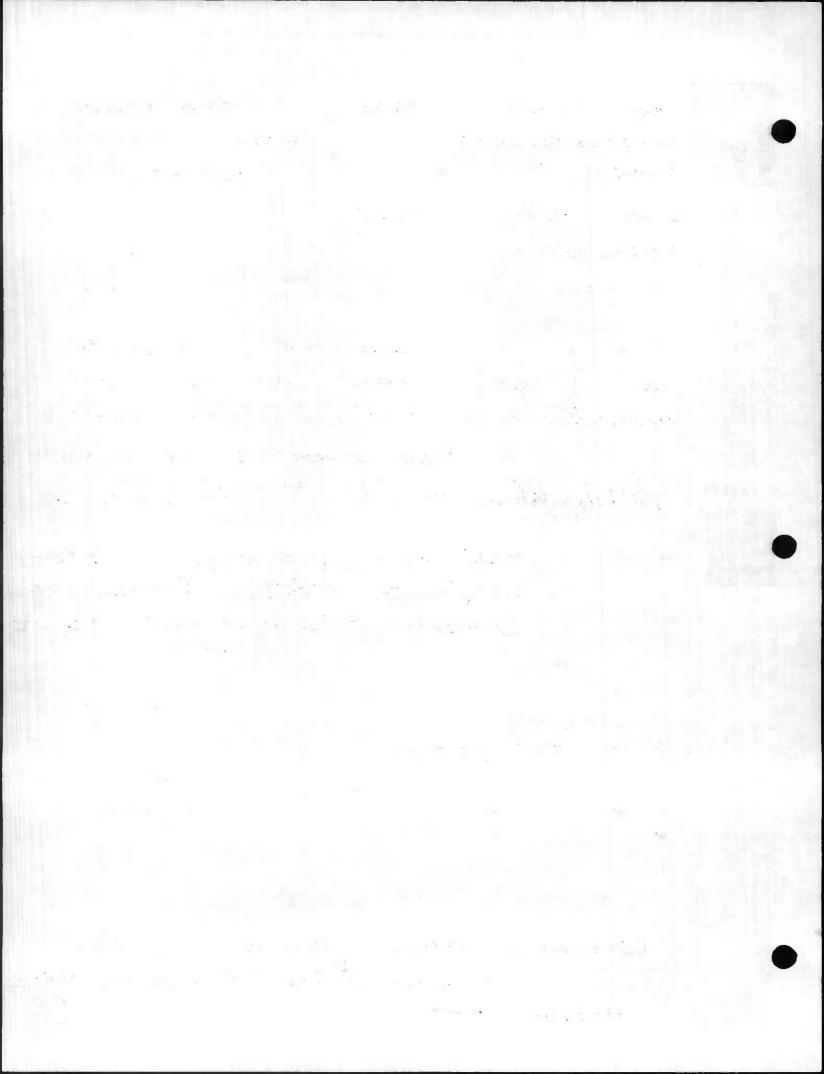
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 作的。24, 1999 Emma Frances Slifer 6 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a. Facility Name (If not institution, give street end number) Examiner Frederick Citizens Nursing Home Frederick If Under 24 Hrs. 8. If Under 1 Year Birthplace (State or Foreign Country)
 M 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Hours 1 M 2 STF Director Yrs 212-72-6649 Usuel Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examiner must be notified at Director 17 Yes 2 No Frederick Middletown Ml. 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 21769 10 E. Green St. U.S.A. Funeral 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispento Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If Itam 27 Is marked other than "natural", or flen eny injury or other traumatic event Black White etc. 1 ☐ Yes 2 1 No If Yes, Give Yeer or Detes: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White à Specify. 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) homemaker own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Lawrence F. Rudy Ehma C. Remsburg 0 19a. Informent's Neme/Relationship (Type, Pnnt) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2438 Old National Pike, Middletown, Md. 21769 Rudy L. Slifer (Son) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donlation 5 ☐ Other (Specify) 2/27 Resthaven Memorial Gardens Frederick, Mil. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. Part1. Enter the disease, or complexions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Bety Onset end Deeth **Physician** /Medical Immediate Ceuse (Final GARGUERE diseese or condition resulting in deeth) Examiner Embolism Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest and Due to (or es e consequenca of): Box 68760, Myocaldial attending physiclan The law requires that the death certificate be Physician/Medical the Due to (or es e consequence of) 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed is Records, 2 cate has been significant page 2 should b 24b. Were eutopsy findings eveilable prior to Be Completed 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 🗷 No certificate 1 ☐ Yes 2 1 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director, it 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To use within 24 hours after To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the cause(s) end menner steted. 29e. Certifier 29b. Signeture end tale of certifier 29c. License number 29d. Date signed (Month, Dey, Year) of death (Item 23e) (Type, Print) 30_Name end edd person who completed cal Medical Ceter Frederick, MD Parkvew -dagrana 31. Dete filed (Month, Day, Year) 32. Registrers Signeture State R 0 2 1999 Registrar

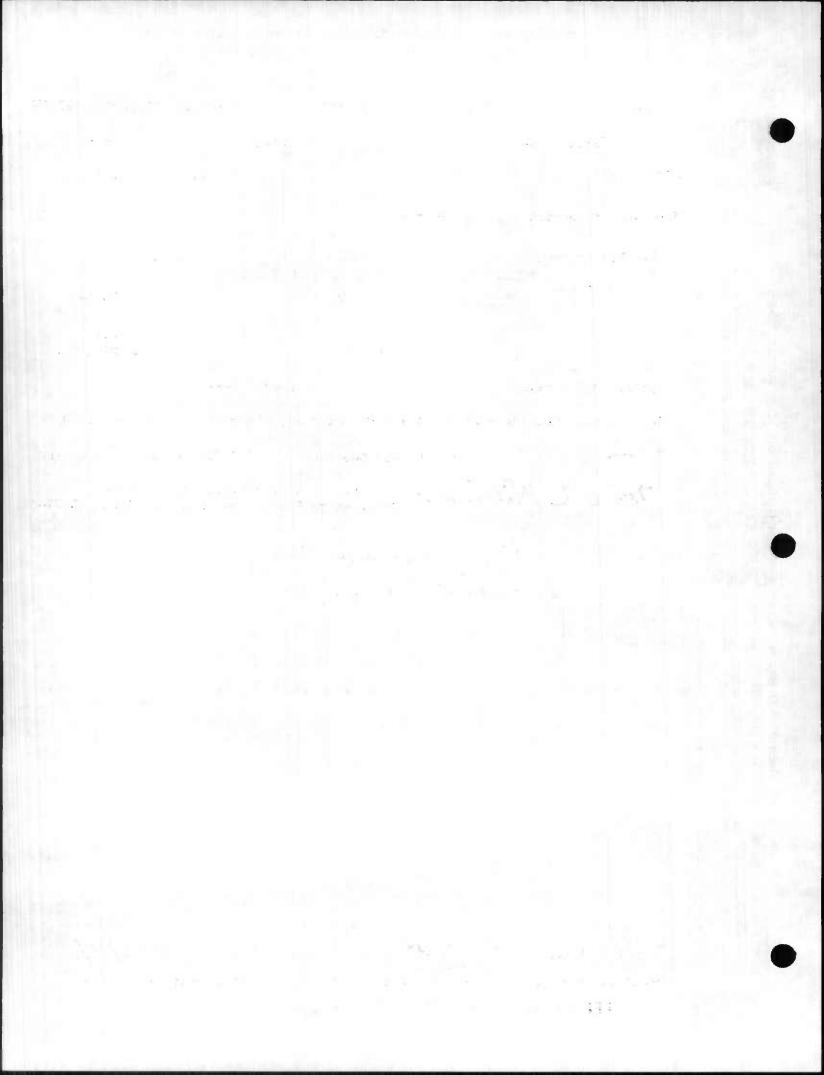
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ysician Medical	1. Decedent's Neme (First, Mic	ddle, Last) IacDonal	.d	SI	EEBOLD		2. Dete of Dea Month FEBRUAR	Day	Year 1999	3. Time of Deeth 2:20 PM
aminer	4e Fecility Neme (If not institut					4b. City, Town, or		4c. County	of Deeth	
	Frederick Mem	-	-		hday) If Under 1 Year	Freder:		Frederick		
eral ctor	5. Social Security Number 578–10–2092	6. Sex 10X M 2		(In yrs. lest birth	months Deys		8. Dete of Birth (Month, Dey Aug 24,	1908	Cour	place (State or Foreignty) ington DC
	Usual Residence of Decedent 10a. Stete 10b. Cour	nty		10c. City, Town	or Location				1	Od. Inside City Limit
tor	Maryland Fr	rederick		Fre	ederick					1 ☐ Yes 2 ☐ N
Be Completed by Funeral Director	10e. Street end Number 5694 Crabapp1	le Drive	2		10f. Zip Code	21703	1	0g. Citizen of V U.S		ntry?
þ	11. Merital Status 1 Never Married 2 M M 3 Widowed 4 Divorce	Arried 1 [es Decedent Emed Forces? Yes 2 XNo Yes, Give per or Detes:		13. Wes Decedent of I If Yes, specify Cub		pecify Yes or No- o Rican, etc.)		ck, White,	can Indien, etc. iite
eted	15. Deced (Specify only high	lent's Education			Decedent's Usuel Occup (Give kind of work done	during most of wor	rking	16b. Kind of B	usiness/in	dustry
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2 Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) **Physician FEBRUARY** 22,1999 8:17 AM JOHN WALTER SCHMIDT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street and number) Examiner 11717 Weller Road Monrovia Frederick If Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1⊠M 2□F Days Hours Min Yrs **Director** 288-16-8736 74 Nov. 7, 1924 Ohio Usual Rasidance of Dacedent with the Marylenc 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23e or 28e-1 show other traumstic event, the Medical Examinar must be notified at 1 Yas 2 No Frederick Monrovia Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11717 Weller Road 21770 U.S.A. Funeral death 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. permit. Pages 1 and 2 should be filed within 72 hours efter d Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or item any injury or other traumatic event, in Medical Energine Black, Whita, etc. 1 X Yas 2 □ No If Yes, Giva Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade com completed) Electronic Elementary/Secondary (0-12) Coitege (1-4or 5+) Machinist Engineering Co. 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) Walter J. Schmidt Marie Cobia 10 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) 11717 Weller Road, Monrovia, Maryland 21770 Alice Leighton Schmidt - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 12 Burial 2 Cremation 3 Ramoval from State Mt. Olivet Cemetery 2/25/99 Frederick, Maryland 4 Donation 5 Othar (Specify) 21. Signature of Funera Sarvice License 22. Nama and Addrass of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland antar tha moda of dying, such as cardiac or respiretory arrest, 20872-0117 Antar tha disaasa, or complications that caused tha daath. Do not antar haart failura. List only ona causa on eech lina. Approximate intarvat Batwean Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in deeth) /Medical 5-15 m Examiner Examiner attending physician end for use as the burial-transit the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Diseasa or injury that initiated avants rasulting in daath) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. tha signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. P 24b. Ware eutopsy findings available prior to Completed 24a. Wes an autopsy peen complation of causa of death? Sec page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificata director. 25. Was cesa rafarrad to madical axaminar? Be 26. Pleca of Death (Check only one) Hospital: Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 28d. Dascribe how Injury occurred 28e. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: or Attending 1 E Natural 5 Pending invastigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) B 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and due to the cause(s) end manner as statad. 29e. Certifia Medicai completaly (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated. within 2 To the 29b. Signatura and titla of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) 700 Montclaire Avenue, Frederick, Maryland Robert S. Hughes, M.D. 21701 31. Data filed (Month, Day, Year) FEB 2 5 1999 32. Regis rar's Signatura State Registrar

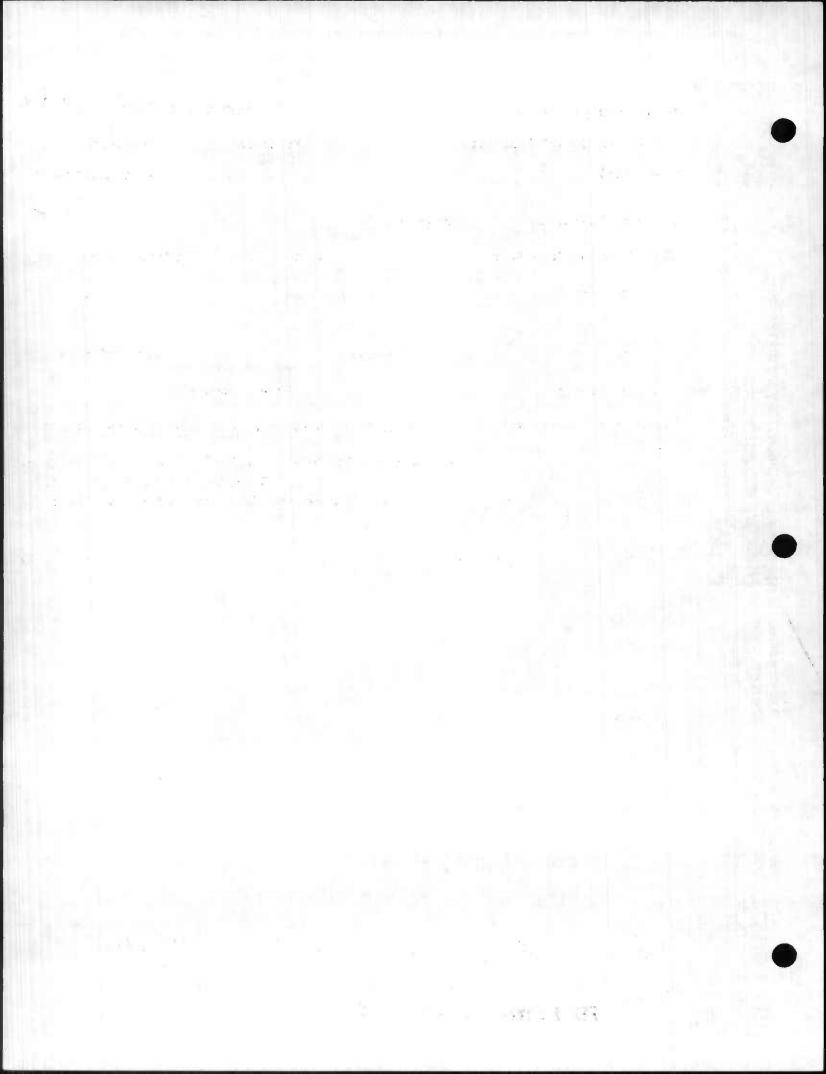


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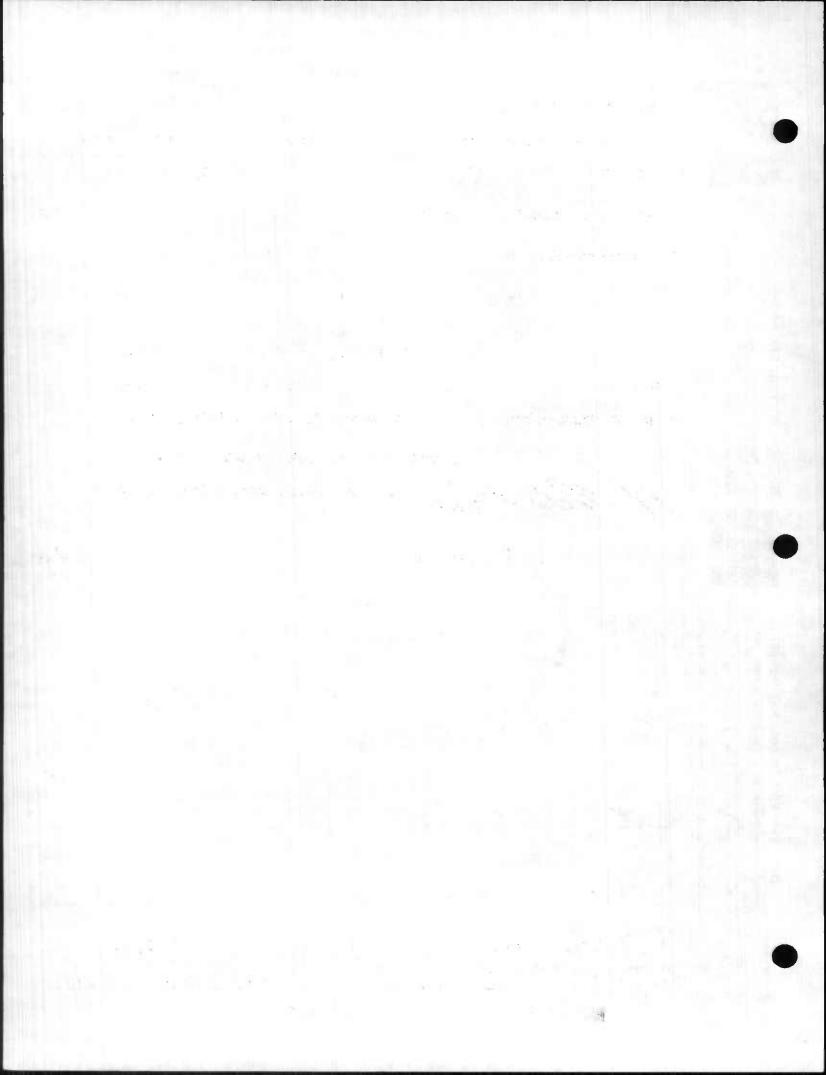
State of Maryland / Department of Health and Mental Hygiene 9 8 0 3 3

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Division	i or Attending efter death. Director: After	Certification:	2 Accident Invastigation 3 Suicida 6 Could not be 4 Homicida detarmined		/ - At homa, fa (Specify)				28f. Location (City or To	Street and Numi vn, State)	ber or Rural	l Route Number,
	To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by	edical C	29a. Cartifiar (Check only one) 1 Certifying Physical Certifician Physical Physi	rsictan: To the best of a liner: On the basis of a and manner state	xamination er	a, deeth occurred nd/or invastigation	at tha ti	me, data and plece opinion, death occu	, and dua to the rred et tha tima,	causa(s) end madata end placa,	annar as sta and dua to	ated. tha causa(s)
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niner	4a Fecility Neme (If						4b. City, Town, or				
	5. Sociel Security Nu	ck Memori		ital 7. Age (In yrs. i	lost hirthday)	If Under 1 Yaar	Freder		Frede		
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	Cyrus	Sturtz					Mabel	l Shoem	aker		
ĺ	19e. Informent's Nam		ype, Print)		19b. Meiling	Address (Stree	et end Number or Ri			Stete, Zip	Code)
	Sarah Wil	Lt Sturtz	, wife		8315	Rocky	Springs I	Road Fr	ederick	MD	21702
	20e. Method of Dispo	sition		C	leca of Disposi	tion (Neme of atory or other ple		Dete	20c. Location -	City or Tov	vn, Stete
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	4 Homicide	determined		g, etc. (Specif)		et, factory, office		City or To	wn, State)	er or nurar	nodie Walliber,
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			State of Ma	aryland	-	artment of artificate o		nd Men		ene g	9 0	8035
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		Anne Arundel Me	dical Cer	nter			Annap			Anne		
Funer Direct		172 20 1170	7. Age 91	e (In yrs. le	yrs.	Months Day		Min. (Dete of Birth Month, Dey,	1907	9. Birthpi Count PA	ece (Stete or Foreign try)
Maryland -f show	tor	Usuel Residence of Decedent 10e. Stete 10b. County MD Anne Arun	ıdel		Town or L fton	ocation					10	0d. Inside City Limits 1 ☐ Yes 2 No
th the	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of \	Whet Coun	try?
th will	al	2131 Davidsonvill	e Rd.				21	114		USA		
-0020 hours after death with the Maryland turel', or items 23a or 28=f show	by Funeral	11. Meritel Stetus 1 Naver Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 XN If Yas, Give Yaar or Datas:		13.	Was Decedent of If Yes, specify Control of Yes, speci		in? (Specify Puarto Rica	Yas or No- n, atc.)	Blac	a - America ck, Whita, e whit	etc.
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within 72 ene.	pldr	Elementery/Secondary (0-12)	College (1-4or 5	+)		e kind of work dor DO NOT use reti						
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ad letter	To Be	17. Fathar's Nama (First, Middla, Last) Michael		Adam			Suza	nne			Zebeno	- 1
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O So T		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☑ R 4 ☐ Donetion 5 ☐ Other (Specify)	amoval from Steta	ce	metery, cre	osition (Neme of emetory or other p		3-4-		Verona		wn, Stata
Baltim permit. Pag Depertment Important: Il	ouce.	21. Signatura of Foneral Service License	" A	01		Rausch I	ress of Facility	1			207	36
filicate be axecuted ax g physician end as the burial-transit	edical Examiner	Immediate Ceuse (Final disease or condition resulting In death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that intitated events resulting in deeth) Lest		Due to (or	es e conse	equenca of): equenca of):						3 days
requires that the death cert been signed by the attendin should be datached for use	eted by Phys	Pert II. Other significent conditions con Dealute Dely	tributing to deeth bu	ut not resul	iting In the	underlying cause	given in Pert I.		23b. Did tol 1 T Ye	a 2 No	3 ☐ Prot	the cause of death? bely 4 Unknow bere eutopsy findings sileble prior to mpletion of cause deeth?
II Rec The law ate has b	dmo								1 □ Ye	s 2 No		Yes 2DM6
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OT VITA Physician: rthis certifical	To Be	evaminer?	lospitel: 1 1 Inpatie	nt oll	R/Outpetie	ent 3 DOA	Other:			nce 6 Oth	ar (Specifi	v)
0 5 5 8		27. Menner of Deeth 1 Paturel 5 Pending 2 Accident investigation	28e. Dete of Injur (Month, De)		28b. Time Injury	of 28c. in		28d.		w Injury occur		<i>"</i>
Division of Attending efter death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28a. Plece of Injubuilding, etc	ury - At hor c. (Specify)	ne, ferm, s	treet, fectory, offic	ca	28f.	Location (St. City or Town		ber or Rura	i Routa Number,
DIVISION O To the Hospital or Attanding Ph within 24 hours efter death. To the Furreral Director: After th completaly filled in by the funeral	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	elclan: To the best of her: On the basis of end menner sta	examineti	fedge, dea on and/or l	th occurred et the nvestigetion, in m	time, dete and y opinion, deet	d pleca, end th occurred e	due to the ca t the time, de	use(s) end m ete end plece,	enner as st and due to	ated. the ceuse(s)
o the	¥	29b. Signature and title of configer				29c. Lice	ense number		29	9d. Data signe	d (Month,	Dey, Year)
F > F 0) Of the	MD			DE	38958	3		3/21	199	
4		30. Name and address of person who co Daleet Singh	mpleted cause of d	141	3 A+		Road		od	enton	am	21113
	State istrar	31. Detectibed (Month, Day, Yeak) MAR 0 3	1999 Negistra	r's Signeti		B. A.	oak	/				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Yaar 225 DA THERESA SITA 1996 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death CLINCON PRINCE GEORGE (CONTHURN MURLIMS HOPPICE CENTER If Undar 24 Hrs. Hours Min. 8. Data of Birth Month, Day, Year) Jan 2, 1907 If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Months Days 1□M 20 F Washington DC 577 84 3914 92 Usual Rasidanca of Dacedani 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas ANO Charles Waldorf 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 12694 Country Lane 20601 United States 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 22 No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Biack, Whita, atc. 1 □ Navar Married 2 □ Married 1□ Yas 2□No Specify. White ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Hame 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Rosina Palmiere Domonick Capparrotta 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) Florence Burdsall (DAUGHTER) 12694 Country Lane, Waldorf, Maryland 20601 20a. Mathod of Disposition 20b. Piaca of Disposition (Nama of camatary, cramatory or other placa) March 4, Date 999 20c. Location - City or Town, State 1 M Buriai 2 Cramation 3 Ramoval from Stata Clinton, Maryland Ressurection Mausoleusm 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of FacilityLee Funeral Home, Inc 6633 Old Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onsat and Daath immediata Causa (Final disaasa or condition resulting in death) Dreumonia (sepsi(6 DAY(Dua to (or as a consequanca of): Dua to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

>q

Completed

Funeral

Director

7 is marked other than "natural", or frems 23s or 28a-f show treumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28 and Injury or other treumatic event, the Medical Exercises 200.00.

Saltimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records.

certificate be

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Examiner physician end s the burial-trans Physician/Medical 80 980 signed by t by Completed funeral director, Be Certification: To

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Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 24a. Was an autopsy performed? 1 Yas 2 700 25. Was casa referred to medical axaminar? 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 patient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Datural 5 Pending 1 ☐ Yas 2 | No invastigation 2 Accident 6 Could not be datermined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 | Homicide

29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to tha causa(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titia of cartifian

VINCENT CHEN, MA

3 Probably 4 Unknown

24b. Wara autopsy findings available prior to

completion of cause of death?

1 Yes 2270

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

mar 2,1999 D18129

State Registrar

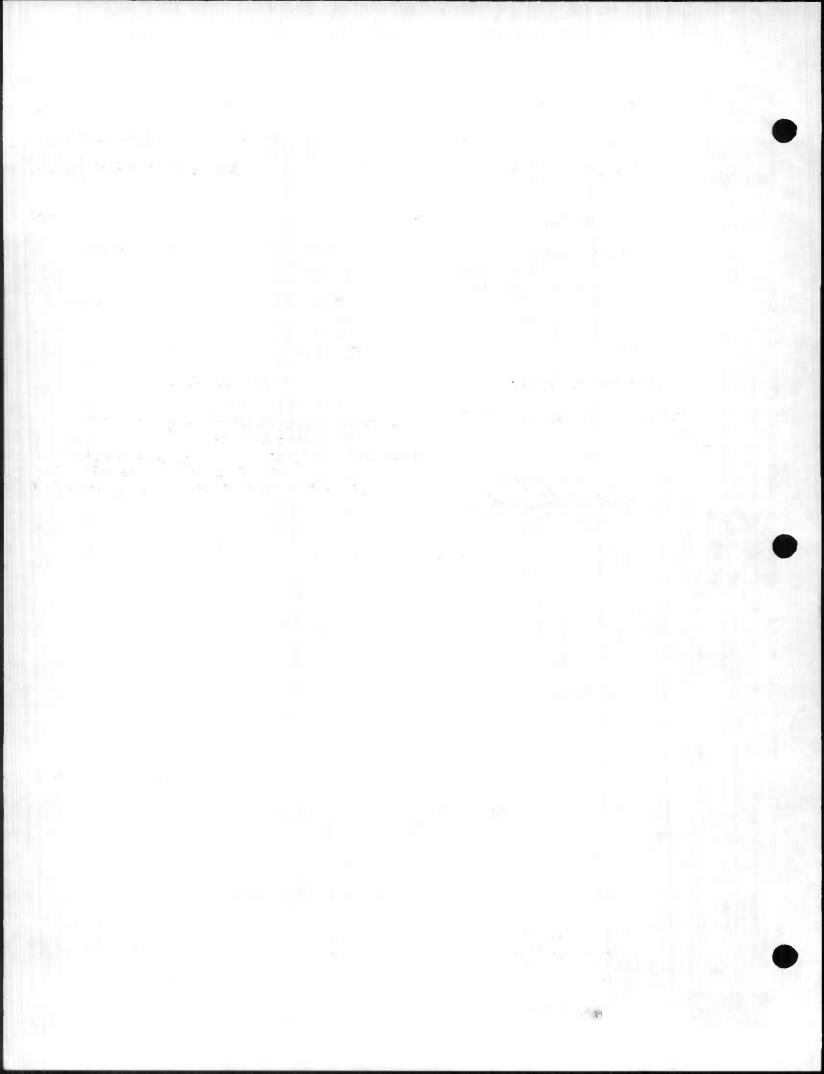
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Medical

31. Data filad (Month, Day, Yeer) 32. Registrar's Signature MAR 0 3 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month DAVID TAMES STEVENS 1, 1999 MARCH 0924 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Prince Frederick Calvert Calvert Memorial Hospital If Undar 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Data of Birth Aug 1924 9. Birthplaca (Stete or Foreign 5. Social Security Number 6. Sex 1√ M 2□ F Months Days Hours Wastrington DC 74 Yrs. 579 38 3128 Usuel Residence of Decedent 10d Inside City Limits 10a State 10b County 10c. City, Town or Location 1 Yes 2 No St. Leonard Maryland Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20685 7251 Bond Street 12. Was Dacadant Evar in U,S. Armed Forces? 1 XYes 2 No If Yas, Give WWI Race - American Indian, Biack, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11 Maritai Status 1 Navar Married 2 Married WWII 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Plumbing Contractor Construction 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Virginia Brannon James Maxwell Stevens 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7251 Bond Street St. Leonard Maryland 20685 19a, informent's Name/Relationship (Type, Print) Janice Lee Stevens- wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) March Metropolitan Funeral Date 20c. Location - City or Town, State 1 1999 ServiceAlexandria Virginia 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sarvice Licensae Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, Approximate Approximate Immediate Causa (Final a. CARDIAC ARRITYTHM/A Due to (or as a consequence of): ONE HOUR disaasa or condition resulting in death) b. CORUNARY ARTERY DISMIN Sequentially list conditions, If any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR DISPAST 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was an autopsy HYPORTHUSION, ATRIAN FIBRILLATION 1 Yes 2 No 1 □ Yes 2 □ No 25. Was cese referred to medice! examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturei 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

The law requires that the deeth certificate be executed Box 68760 P.O. Division of Vital Attending Physician: **Physician**

/Medical

Examiner

Directo

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Modical Examiner must be notified at

permit. Pages 1 end 2 should be file Department of Health end Mentel Hy, Important: if I tem 27 is marked other important or other traumstic event, pace.

Physician /Medical

Examiner

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Physician/Medical

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Certification:

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filed within 72 hours after deeth Hygiene. rther than "natural", or items 23

Baltimore, Maryland 21215-0020

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certificate this After this funeral Division

To the Hospital or Attendit
within 24 hours effer death.

To the Funeral Director: All
completely filled in by the It. death.

29a. Certifier (Check only one)

29c. License number

12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner ss steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end manner stated.

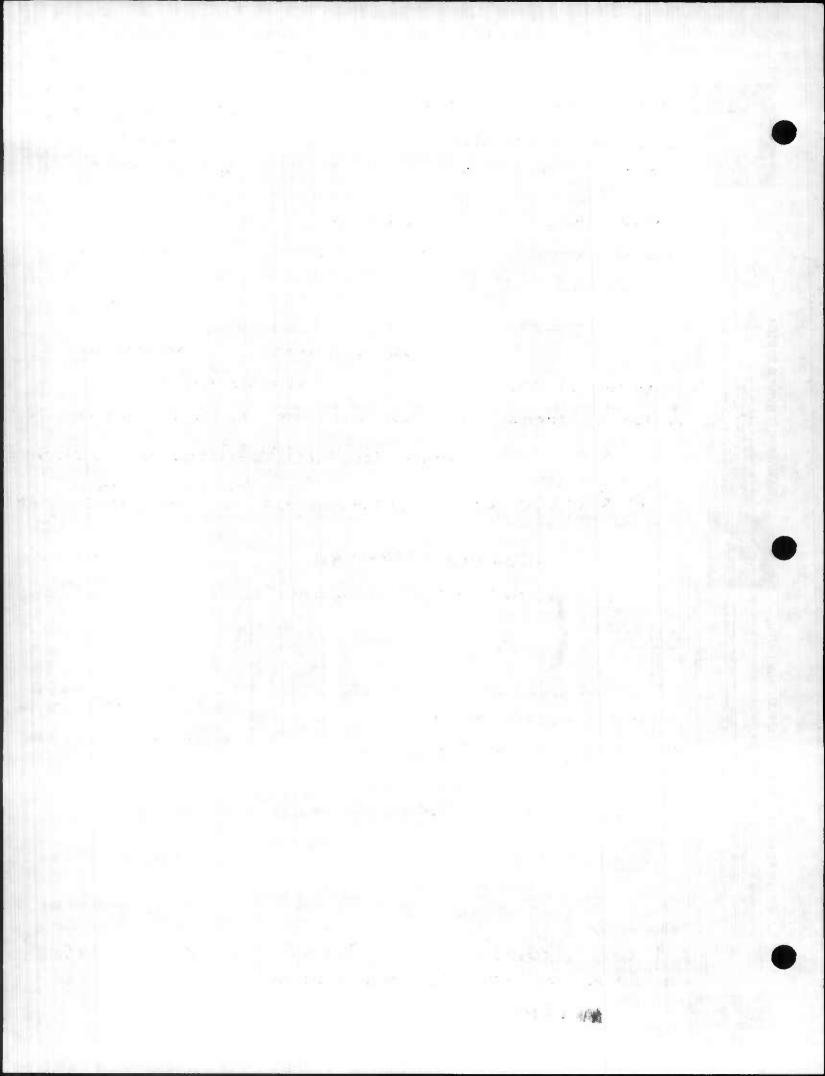
29b. Signature and 126 of certifier

D26358

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cluse of death (Item 23a) (Type, Print)
Dr. John H. Weigel, M.D., Prince Frederick, MD 20678

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 2 1999

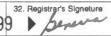


State Registrar

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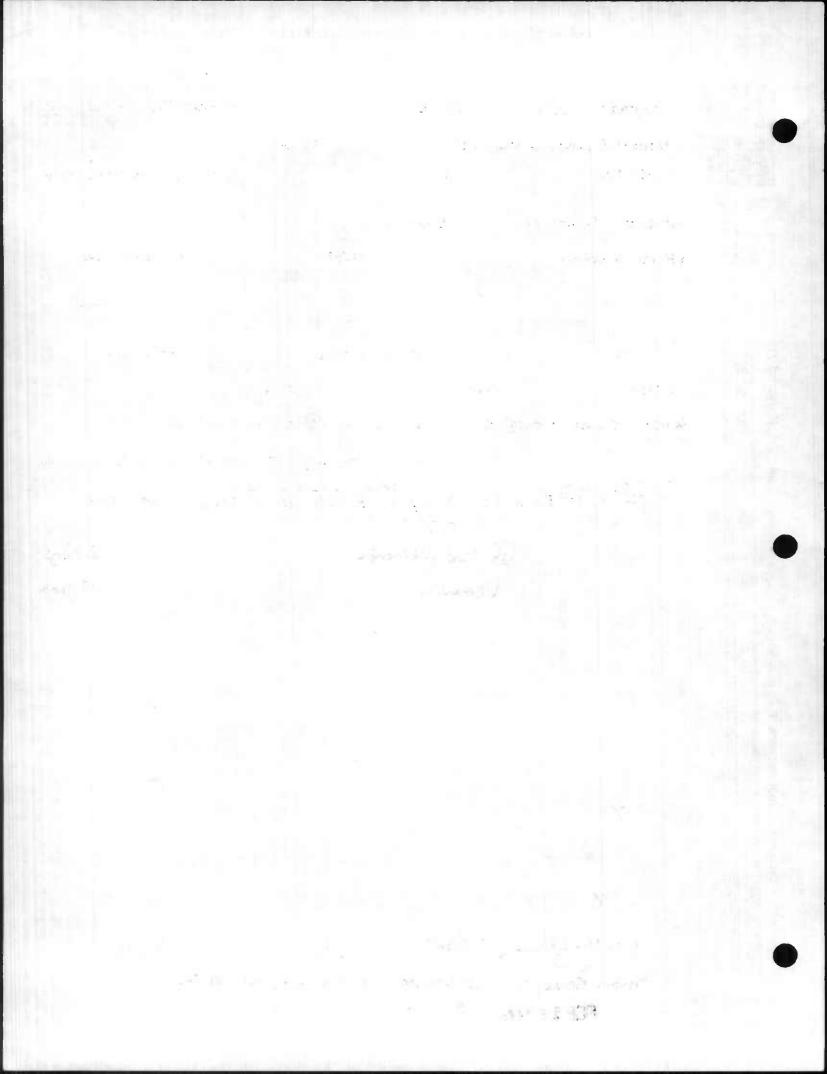
30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

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B. Sporks

111 Penn Street, Baltimore, Maryland 21201

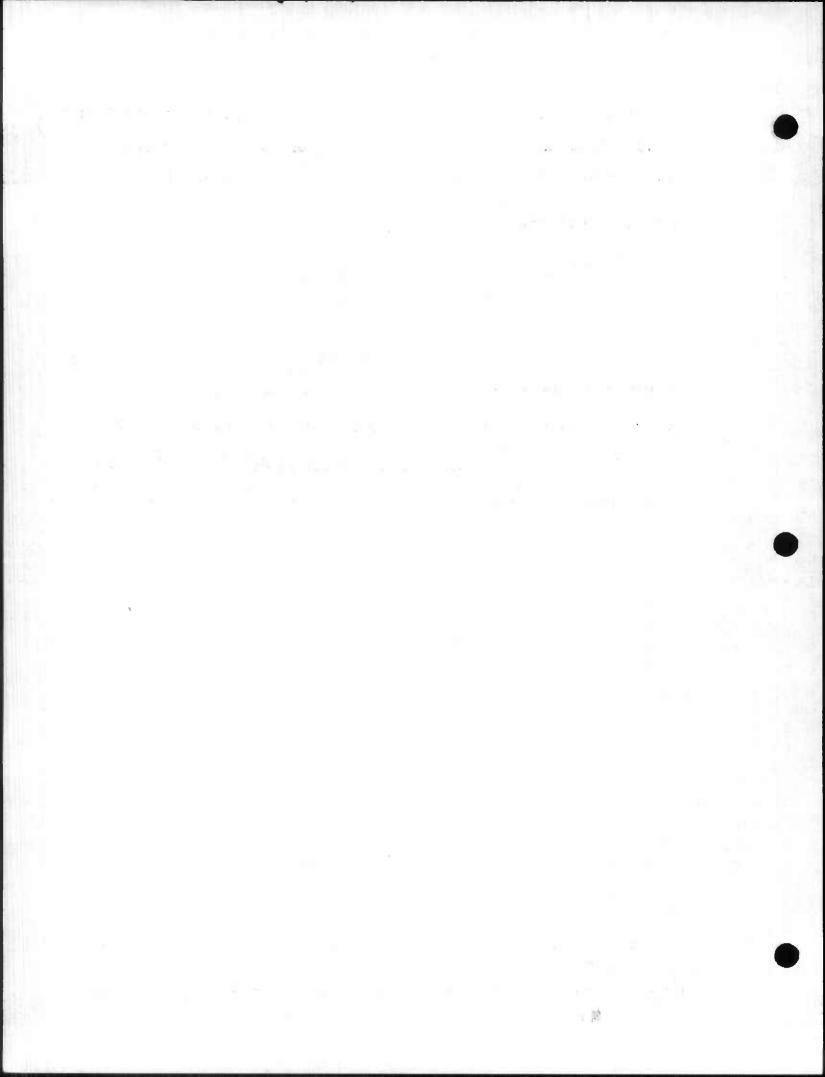
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	or 28	Funeral Director	10e. Street and Number					10f. Zip C	Code				10g. Citizen of V			
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State of Maryland / Department of Health and Mental Hygiene 00

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Z	72 hours after death with the Maryland natural; or items 23s or 28s-f show dost Exercinet must be netfied at	by	3 ☐ Widowed 4 ☐ Divorced	1 Yas 2 If Yas, Give Yaar or Datas:		10	⊒Yas 2. AN	Specify:		Specif	whit	rates rican Indian, a, atc. te Industry Industry Tip Code) Town, Stata
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exacting traut by notified at Angle.		1 ☐ Buriai 2 ☐ Cramation 3 [Ramovai from Stata		-	tory or other pi	1	March 2,	1999		
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-	he al	sic	Part ff. Other significant conditions	ontributing to death b	ut not rasulting	g in tha und	larlying causa g	iven in Part f.	23b. Dld t	obacco use co	entribute to t	he cause of death?
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	es tha igned be de	þ										
5	v require been si should	Pe							24a. Was			a autopsy findings lable prior to
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_	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific complately filled in by the funeral director.		29a. Cartifiar 3K Certifying Pl	nysician: To the best of	of my knowled	lan doath a	accurred at the	time data and since	and due to the	auga/a) and m		lad.
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	and *		Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City, Tow	n or Loc	ation					11	Od. Inside City Limits
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P.O. B	tha d ny the ached	y Physician/M	Part II. Other eignificant conditions of	ontributing to death bu	t not rasulting in	n tha und	,	van in Part I.	*		o use cor	atribute to	the cause of death?
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ō	F E	1-1	27. Mannar of Deeth	25a. Date of Injury	28b. 1	Time of	28c Inju		28d. Describe				9
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 1. Decedent's Nama (First, Middle, Last) 3. Time of Death February 24, 1999 **Physician** Francis William Wagner 4:15 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6. Sex 1∆ M 2□ F 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foraign Country) **Funeral** Yrs. 217-10-0550 83 Director Oct. 27, 1915 Maryland Usuel Residence of Decedent the Meryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hygiana.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic avant, the Medical Examples must be notified at page. 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Frederick Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1005 East Patrick Street 21701 U.S.A. Funeral Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 Yes 2X No Specify þ 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/industry Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver Trucking 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fathar's Nema (First, Middla, Last) Clarence Wagner Nettie Virginia Simpson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) Doris Smith (Daughter) 6105 D Quinn Road, Frederick, Maryland 21701 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crametory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stata Mount Olivet Cemetery 2/27/99 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funer 22. Name and Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 Do not enter the mode of dying, such as cerdiac or respiretory errest, 23e. Part1. Enter the disease, or complications that caused the deshock, or hear failure. List only one cause on each line. Approximete Intervai Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical 16 your CEN **Examiner** Due to (or es e consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es e consequence of): ettending pl ed by the e Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed Aftar this certificata hes funeral director, page 2: 1 Yes 2 XNo Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specity) 2 1 Yes 25 No 1 ⊠Inpatient 2 □ ER/Outpatient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. fnjury et Work? 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicida 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 24 hours after Funeral Directors 4 Homicide 29a. Certifier edicai Ecritifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. To the Hosp within 24 ho To the Fune complately fi (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) end mennar steted. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) w 9th Steet Frelie BARAKA Lusa 310 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State FEB 2 6 1999 Registrar

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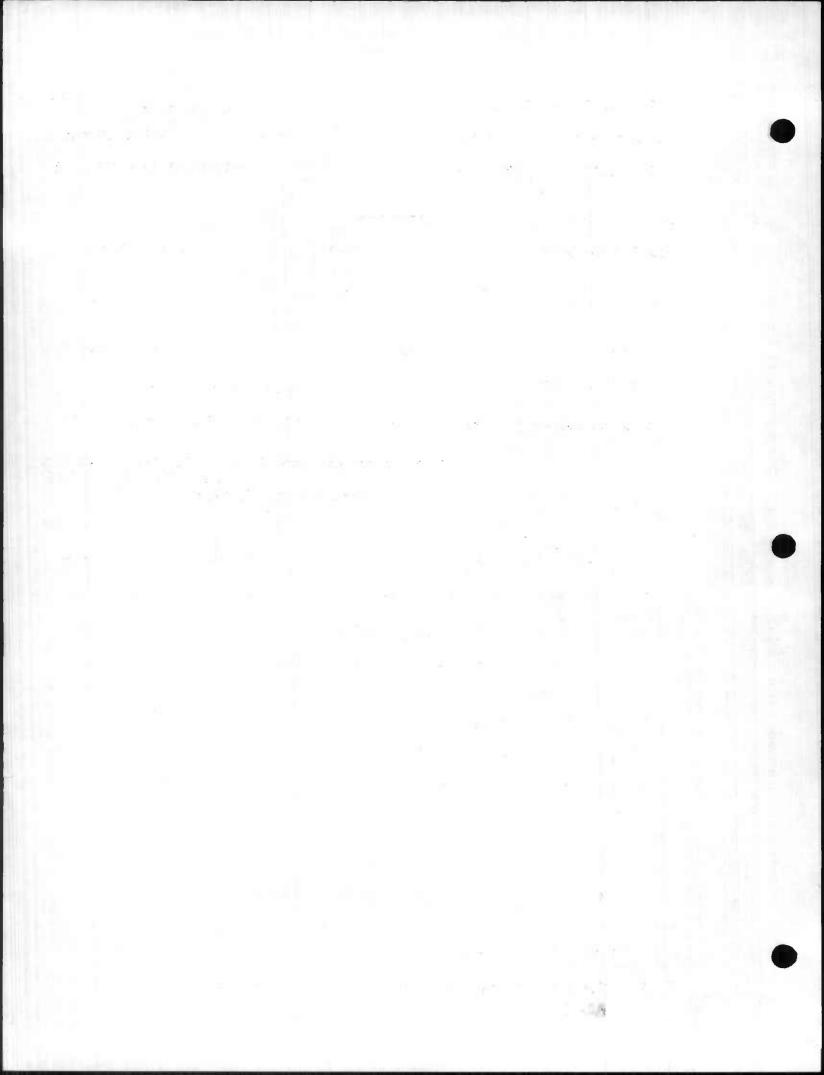
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 8:15 P.M Elizabeth Jessie Walker Feb 27, 1999 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince George's Clinton Southern Maryland Hospital If Under 24 Hrs. 8. Dete of Birth
July 13, Year 1909

Birthplece (Stete or Foreign
Philla, PA 5. Sociel Security Number 7. Age (in yrs. last birthdey) If Under 1 Year **Funeral** Deys Hours 1□ M 3/7/F Months 89 179 09 4317 Director Usuel Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. inside City Limits 10b County 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examinar main be notified at 1 ☐ Yes 2 ☐ X 0 Director Brandywine MD P.G. 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 20613 United States 15202 Croom Road Funeral death 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. Wes Decedent Ever in U,S. Armed Forces? 11 Merital Status Peges 1 and 2 should be filed within 72 hours effer in and Mental Hygiene.
It is them 27 is marked other than "natural", or her 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 Yes PNo Specify: 3altimore, Maryland 21215-0020 Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) 9th College (1-4or 5+) Department Store Sales 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Thomas Henry Buck Jessie Brown Cameron 19a, Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 15202 Croom Road, Brandywine, Maryland 20613 William J. Walker (HUSBAND) 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 0 Fort Lincoln Cemetery March 3,99 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting In deeth) Isdiemic cardio sugo pathy 200.020 Years Examiner Due to (or es e consequenca of): Examiner tadycerdia a cardiac anost attending physician and for use es the burial-transit Recoment ventrialer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequenca of): P.O. Box 68760, Due to (or es e consequence of): Year Physician/Medical Recurrent aspiration Brondits Leann ed by the a Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 Unknown 1 Yes 2 No 3 astro escapaged replax Records, by 24b. Were eutopsy findings avellable prior to completion of cause of deeth? 24a. Wes en eutopsy Completed alou coma Debressions 2 No 1 Tyes 2 No 1 Yes Division of Vital congestion of PRSSIVE e Hospital or Attending Physician: 24 hours altar daath. • Funeral Director: After this certifical etaly filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of Certification: 5 Pending investigation 1 Neturel 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 1DC Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hou To the Funer completely fil (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Poter w. D12884 2-08 99 10 PEDR W. YTM AND

31. Dete filed (Month, Day, Year) 7900 Old Branch suite los Clinton, newland 32. Registrar's Signature State Jener Registrar

DHMH 16 Rev 6/95



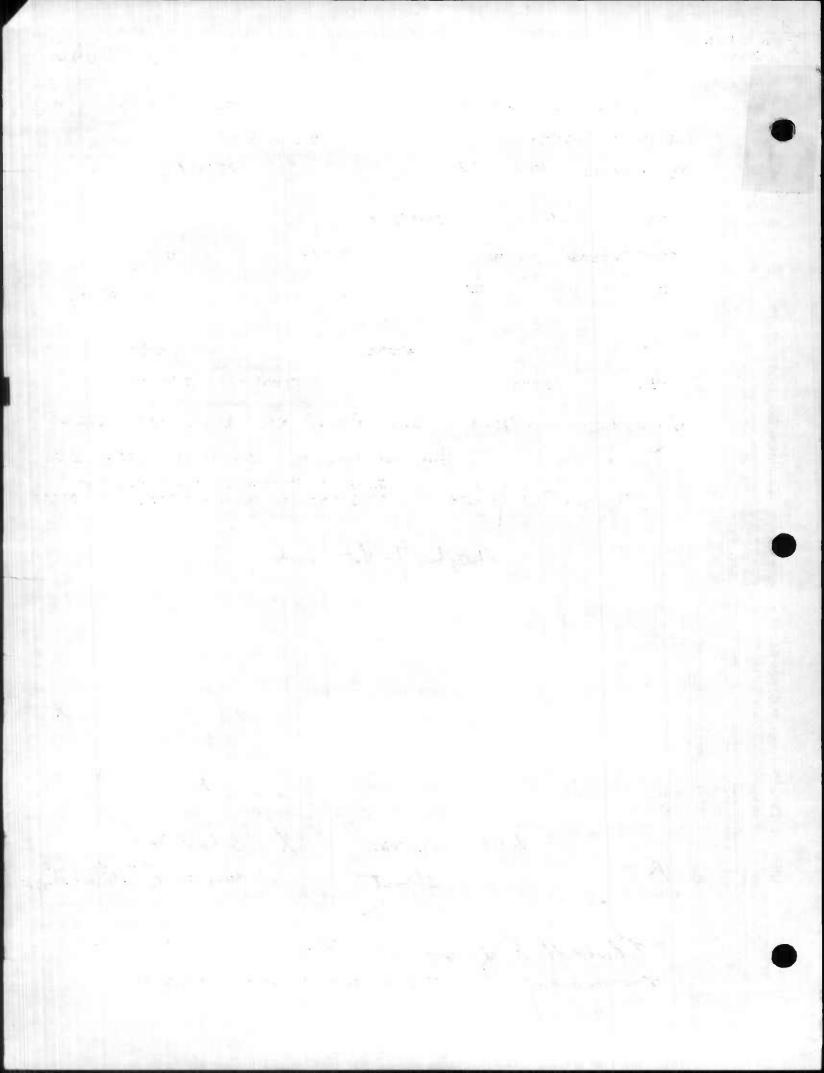
State of Maryland / Department of Health and Mental Hygiene 9 9

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hysician /Medical	EMMETT	MO	RGAN			WEBB				FEBRUAR			05	10 am
/Medical Examiner	4a Facility Nama (If not institu			r)				4b. City, To		ocation of Death				LO_GII
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or 284-1 s be notified Director	10e. Street and Number					10f. Zip	Coda			10g. Citizan of What Country?				
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r, tre Wodes Completed	15. Dece	dant's Edu			16a. Decedant's Usual Occupation						16b. Kind of B	usinass/Inc	dustry	
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mportant: if flem 27 is marke any Injury or other treumatic pace.	20a. Mathod of Disposition 1 Burial 2 □ Cramati	on 3 🗆 F	Ramoval from State	20b. Pl	aca of Disp matary, cra LCTEST	osition (Name matery or o	na of other pie	neter	,	Data 20c. Location - City or Town, Stata 3-2-99 Annapolis, MD				
la Jan	4 Donation 5 Otha													
any Injury or	21. Signatura of Funeral Sarvice Licansaa 22. Nama and Addrass of Facility Rausch Funeral Home, Owings, MD 20736													
	23a. Part1. Entar tha disaasa shock, or haart failure.	23a. Part1. Entar tha disaasa, or complications that caesad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onset and Death												
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State of Maryland / Department of Health and Mental Hygiene 0 001.5

-1389-510	Certificate of Death		22	08043		
	1. Decedent's Name (First, Middle, Last)	2. Date of Dec		3. Time of Death		
Physician	Brian E, Artson	Month MARCH	Dey 10,	Year 1999 1320 PM		
/ /Medical Examiner	4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Lor	cation of Death				
	UNIVERSITY HOSPITAL BALTIMORE			Afficia School Co.		
Funeral Director	5. Social Security Number 218-02-4544 Cusuel Residence of Decedent 6. Sex 1 Monthe Deys Hours Min. 7. Aga (In yrs. lest birthday) 16 Yrs. 7. Aga (In yrs. lest birthday) 16 Yrs. 17. Aga (In yrs. lest birthday) 18 Under 19 Year If Under 24 Hrs. Monthe Deys Hours Min.	8. Date of Birth Be	0/83	Birthplece (State or Foreign Country) MD		
land	10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits		
death with the Maryland ms 23a or 28s-1 show Linust be notified at neral Director	MD n/a Baltimore			XXYes 2□No		
ith the M or 28s-f or cuts	10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Country?		
23a 23a raf D	2227 Penrose Avenue 21223		USA			
r the	11. Maritel Stetus 12. Was Decadant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ Morited 1 ☐ Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puarto if 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No Rican, atc.)	- 14. Race Bleck	- Amarican Indian, k, White, etc. Black		
5-0 72 ho 72 ho natur	15. Decedent's Education 16e. Decedent's Usual Occupetion (Specify only highest grade completed) (Give kind of work done during most of working the complete of the complete o	ina	16b. Kind of Bu	siness/industry		
yore, Maryland 21215-002 gas 1 and 2 should be filed within 72 hours at of Health and Mental Hygiene. If them 27 is marked other than "naturat", or other traumatic event, the Medical Exergence of the filed by To Be Completed by	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Student		aaha	201		
d 2 Hilled v Hygie Hygie Hygie Co		/First Middle	school irst, Middle, Meiden Sumeme)			
should be filed of Mental Hyginaric event, I To Be Co	Eric W. Artson Caroly		Johnson	,		
Maryland Id 2 should be file th end Mental th T is marked oth traumatic event	19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rura	al Route Numbe	er, City or Town,	Stete, Zip Code)		
1 end 2 street Health er m 27 le	Carolyn Johnson Mother 2227 Penrose Ave.	Balt	o., Md.	21223		
of He of He	20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetery or other plece)	Dete		City or Town, Stete		
Pa Pa	4 Donation 5 Other (Specify) Garrison Forest 3	-16-99	Owings	Mills MD.		
Baltimore, M permit. Pages 1 end Department of Health Important: If Item 27 any Injury or other ti	21. Signature of Funeral Service Licensea 22. Name end Address of Facility James A. Mortor 1701 Laurens St					
Physician /Medical Examiner	23e. Per Cells the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac of shock or heart feilure. List only one cause of each line. Immediate Cause (Finel disease or condition resulting in death) e			Approximate Interval Between Onset end Death		
lecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician and 1.2 should be detached for use as the burial-transit npleted by Physician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In deeth) Last Dua to (or as a consequence of): Dua to (or as a consequence of):					
Geath death death of for sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.	23b. Dld	tobacco use con	tribute to the cause of death?		
ds, P.O. Box vires that the death cent signed by the attending d be detached for use of		10	Yes 2□ No	3 □ Probably 4 Unknown		
The law requires to the law requires to the law been signed page 2 should be completed by		24e. Wes perfo	en eutopsy rmed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?		
I Relay The lay pega 2		1	Yes 2□No	10 Yes 2□ No		
Vital Indicates The certificate rector, pec	25. Wes case referred to medical examiner?	Check only	one)			
Of Vital Physician: Trinis certificate ral director, pe			dence 6 Othe			
After funer funer	1 Naturel 5 Pending (Month, Dey Year) Injury Work?	28d. Describe	how injury occurr	90		
Division of tall or Attending P as after death. al Director: After to death by the funers death by the funers of	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (S City or Tow Holling S	Street and Number of Stete)	er or Rurel Route Number,		
Division of Vital Re To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completaly filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) 1 Cartifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and place is a place of examination and/or investigation, in my opinion, deeth occurred and manner stated.	end due to the	ceuse(s) end mei dete end plece, e	nner es stated. and due to the cause(s)		
Withir Comp	29b. Signeture end title of certifier 29c. License number		29d. Dete signed	(Month, Dey, Year)		
	Theorbee U. H. of an OCME		MARCH 1	1, 1999		
3 1833	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THEODORE M.K. 1111 Penn Street, Baltimore	e, Mary	vland 21	201		
State Registrar	31. Dete filed (Month, Dey, Year) MAR 15 1999 32. Registrar's Signature					

DHMH 16 Rev 6/95



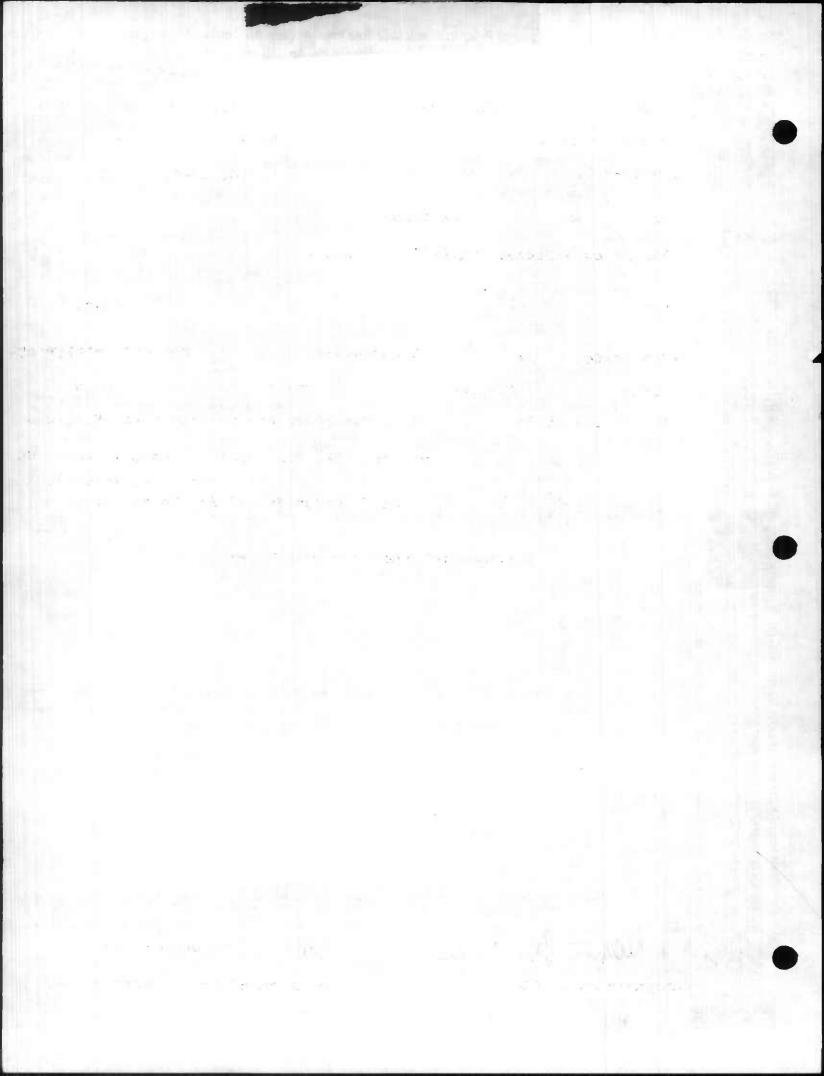
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State of Maryland / Department of Health and Mental Hygiene

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ATKINSON				Ce	rtificate (of De	eath		Re	g. No.	00	0 40	
Physician	1. Decedent's Nama (First, Mid								Data of Daath Month	Day	Year	3. Tima of Death	
· /Medica	Ruch		Atkins	on		Ab (City Tourn	MARCH Town, or Location of Death				8:57P.M.	
Examine	4a Facility Name (If not institut ST.AGNES HOSI		umber)			E	BALTI	MORE		NA			
Funeral Director	5. Social Security Number 219-22-9609	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 71	last birthday) Yrs.	If Undar 1 Y Months Da		Under 24 Hours	Min.	8. Date of Birth (Month, Day, Year) 03-25-27		9. Birthplace (Stata or Fo		
Merylend f show	Usual Residence of Decedent 10e. State 10b. Coun 5 MD N	*		ty, Town or Lo							10	0d. Inside City Limits 1X Yas 2 □ No	
with the Mer Sa or 28s-f si	10e. Street and Number 501 Dolphi	n Street	Apt.#	913	10f. Zip Co	de 217			10g. Citizen of What			Country?	
15-0020 72 hours efter death with the Meryland "natural", or items 23a or 28a-f show edical Examinat must be notified at	11. Marital Status 1 Nevar Married 2 M	12. Was De Armed F arried 1 \(\superscript{Yes} \)	cedent Evar in U Forces? 30 No	J,S. 13.	Was Decedent If Yes, specify		Hispanic Origin? (Specify Yes or No pan, Mexican, Puerto Rican, atc.) Specify:			o- 14. Race - American Indian, Black, White, etc. Specify: Black		etc.	
ed within 72 hot ygiene.			(1-4or 5+)	(Give	dent's Usual On kind of work do DO NOT use re	ona duri etired)	ing most of	f working		Region		_{dustry} Managemen	
be fill H d out	17. Fathar's Nama (First, Middl		mpson	1100	Белеер	-				Aalden Sumem			
E = 0 N	19e. Informent's Name/Reletio	19e. Informent's Name/Reletionship (Type, Print) Sheila Sule-Gold					nd Number or Rural Routa Number, City or Town, State, Zip Code) ood Avenue Baltimore, Mar						
Peges nent of nnt: If it	20a. Method of Disposition ★□ Burial 2 □ Cremation 4 □ Donation 5 □ Other		n State	cemetery, cre	osition (Nama of matory or other Mem. F	placa)	Cem.			9 Rand		wn, State stown, MD	
Baltimo permit. Peg Department. Important: If my Injury o	21. Signature of Funeral Service	e Licensee	6.0	,	2. Name and A						_	nd 21202	
Physician /Medical Examiner	23a. Fart1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in deeth)		rioscler	,	ardiova					sst,		Approximate Interval Between Onset and Death	
Box 68760, eath certificate be executed ettending physicien end for use as the burial-transit	Ceuse (Diseese or Injury that initiated avents resulting In deeth) Last	c		or as a conse									
P.O. net the d d by the leteched		tions contributing to	death but not re	sulting In the u	inderlying caus	e given	In Part I.					o the cause of death?	
SCOrd aw requir is been s 2 should					E/I				24a. Was ar perform INSPEC	ned?	ava	ere autopsy findings allable prior to mplation of cause death?	
Vita	25. Was case referred to media examiner?	Hospital:	Inpetient 2	XER/Outpetie	nt 3□ DOA	2 Other:			1 ☐ Ye			Yas 2 No	
Oivision or or Attending Physical death. Infection: After this in by the funeral		ling (Mo	e of Injury nth, Dey Year) ce of Injury - At I ding, etc. (Speci	28b. Time of Injury	of 28c.			28d.	Describe ho	w Injury occur	rred	Il Route Number,	
To the Hospital within 24 hours To the Funeral Egympletely filled		ring Physician: To the at Examiner: On the and ma											
To T	29b. Signation and title of cartin	Mel	Sulla use of death (Ite	m 23a) (Type,	0	.C.N				9d. Data signe			
State	Margarita Koro 31. Date filed (Month, Day, Yea	ell M.D.	Registrar's Sign		111 Pe			t, Ba	ltimor	re, Mar	yland	1 21201	
Registrar	KAR I	1999	place of	D.	Door	Res							

DHMH 16 Rev 6/95

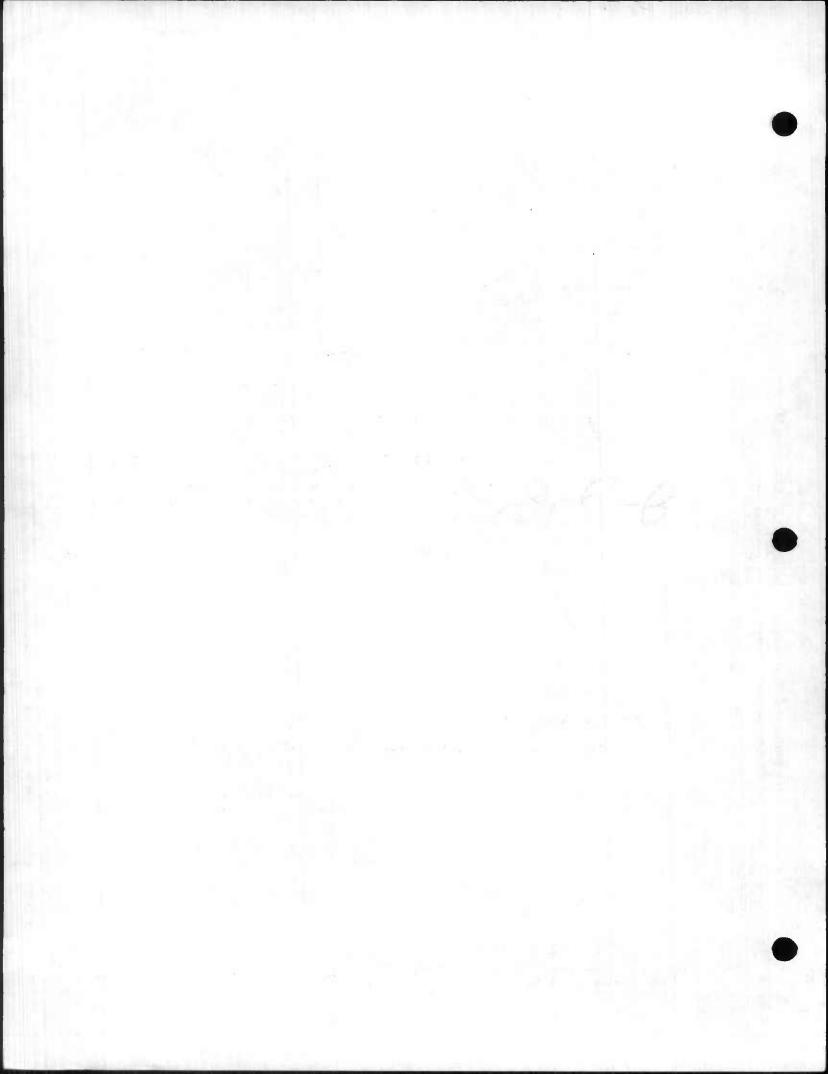


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death . Day 1999 March 13, **Physician** Raymond Sylvester Atkinson 7:20 pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5272 Millfield Road Rosedale Baltimore If Under 24 Hrs 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) Funeral Days Months Hours 1⊠M 2□ F 216-03-2579 92 March 31, 1906 Maryland Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at the Maryle Baltimore 1 □ Yes 2 No Maryland Rosedale Director 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 5272 Millfield Road 21237 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White À 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Higher than "n Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Florist permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygie Important: If Isen 27 is marked other I any Injury or other traumatic event. It 17 Father's Name (First Middle Lest) 18 Mother's Name /First Middle Maiden Sumeme Be John Edward Atkinson Carrie Jones 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Marleen Atkinson (Daughter) 5272 Millfield Road, Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Purial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Oak Lawn Cemetery 3/17/99 Baltimore, Maryland 22. Nama and Addrass of Fecility nature of Fuseral Service Licens Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximete Intervel Between Onsat and Daath **Physician** /Medical Immediate Cause (Final Cancer MOS diseasa or condition rasulting in death) Examiner Examiner the bunal-transit certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last pue Due to (or as a consequence of): Box 68760. attending physician Physician/Medical Due to (or as a consequence of): 65 Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobação use contribute to the cause of death? Division of Vital Records, P.O. 4 signed by the 1 Yes 2 No 3 Probably 4 Unknown prostate hy perhoph by 24a. Was en eutopsy performed? 24b. Were eutopsy lindings available prior to Completed Deen Phybly sema completion of cause of death? page 2 s Seu 1 ☐ Yas 2 DNo 1 ☐ Yas 2 ☐ No certificate 25. Was case raferred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa Statement 6 Other (Specify) To 1 ☐ Yas 2K No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this To the Hospital or Attending rrry within 24 hours after death. To the Funeral Director: After thi funeral 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: 5 Pending invastigation 1 X Natural 1 Yes 2 No 2 ☐ Accident 6 Could not be detarmined 3 ☐ Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of comilie 4628 MARCH 15, 1999 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Chen 13/49 1792 Mercil 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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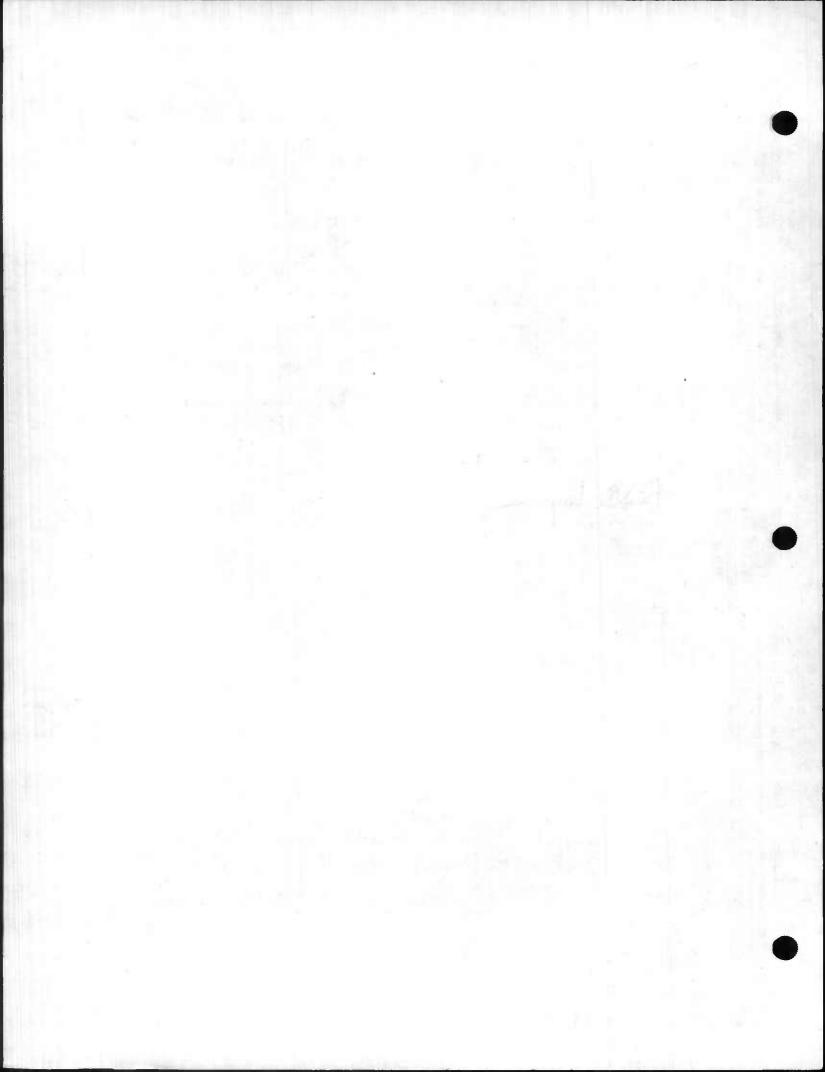
DHMH 16 Rev 6/95



		Item: 20b per F.H G-769			partment ertificate				Reg. No.	080	48
	hysician		Γ.	7.5				Month	Day	Year 1999	PP.M
Y	/Medical Examiner	JAMES 4a Facility Name (If not Institution, given			ENNETT	4b. Ci	ty, Town, or Lo		1) / (
	- Administr	NORTH ARUNDEL HO	SPITAL.			G	LEN BUF	NIE		ANNE AF	UNDEL.
Fu	ineral	5. Social Security Number 6. 5	Sex 7. Age (/	n yrs. lest birthda	Months [Year If t	Inder 24 Hrs. ours Min.	8. Date of Bir (Month, De	th Veer)		State or Foreign
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2		Usual Residence of Decedent 10a. Stete 10b. County	4/	0c. City, Town or	Logation					104 1-	side City Limits
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et M	or 28s-f s be notified Director	MARYLAND ANNE AI	RUNDEL	G	LEN BURN			T	ton Obiner of I		
with	23e or 28e-f sho unt be notified at ral Director		03D		10f. Zip C		061		10g. Citizen of \		
tie e	eral era	7520 HOLLYBROOK I	12. Wes Decedent Eve	rin IJS 1	3 Was Deceder			city Yes or No	U.S	e - American Inc	dian.
	if, or home 234	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? X☐ Yes 2☐ No If Yes, Give Yeer or Detes:	1949- 1976	3. Was Deceder if Yes, specify 1 ☐ Yes 2 ☑			Rican, etc.)	Blac Specify	ck, White, etc.	
21215-0020 d within 72 hours at piene.		15. Decedent's E	7-11	16a. De	cedent's Usual (Occupation			16b. Kind of B	usiness/Industry	
215 Nin 72	t, the Medical	(Specify only highest gra	college (1-4or 5+)	(Gi	ive kind of work i B. DO NOT use	vork done during most of working					
212 d with giene.	omp	12	Oollege (1-401 54)	INS	PECTOR-0	CORP	OF ENGI	NEERS	U.	S. GOVE	RNMENT
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should be	marked other martic svant, to To Be Co	WALTER		BE	NNETT		ELIZABE	TH		LONG	MIR
20	7 Is marked other than traumatic sysrit, the M Tro Be Comp	19a. tnformant's Name/Relationship (Charles of the Charles				er, City or Town,		
. 59	100	ELSE BENNETT	(WIFE)	20b. Plece of Dis			ROAD,	GLEN E	BURNIE,		
Baltimore	ary or of	20a. Method of Disposition 1 Burial 2 Cremation 3 5 4 Donation 5 Other (Specif	Removel from State	cemetery, of	cremetory or other	er place)		/16/99		City or Town, S	
Balt permit. Departs	any inj	21. Speature of Funeral Service Licer	1500		22. Name and		. 51		FUNERA EN BURNI		
/Me Example of the period of t	attending physician and a find the burial-transit for use as the burial for us	23a. Part I. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest	b. Due	e to (or as a cons	Sequence of):					Onse	et and Death
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. 0	igned by the attending price of the detached for use est to detached for use est to be detached for use est to be detached for use est to be detached for use of the detached by physician/Med	Part II. Other aignificant conditions of SCVENET D	a series of the		, ,	se given in	Part I.		tobacco use co Yes 2□ No		
Cord	should should	SEVERE D Decubitus Gastro-2nt	ulless						an autopsy ormed?	available	atopsy findings a prior to ion of cause ?
He la	page 2	Gastro- Int	ghial !	Shede	ing.			t D	Yes 2DNo	1 ☐ Yes	20N6
	s certificate hadinector, page director, page To Be Com	25. Was case referred to medical			0	26.	Place of Deeth	(Check only	one)		
- 5 :		examiner?	Hospital: Inpatient	2 ER/Outpa	tient 3 DOA	Other: 4	☐ Nursing Ho	me 5 Resi	dence 6 □Oth	ner (Specify)	
Division of To the Hospital or Attending Physinia 24 hours after death.	Section: After the led in by the funeral Certification:	27. Mannerof Death 1. Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	e one place of taken	- At home, farm,	М	. Injury at Work? 1 Yes	2 🗆 No	28f. Location (Street and Number, Steet)		ite Number,
ne Hospital n 24 hours	pletely filled edical C		ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or							cause(s)
To th	N S	29b. Signature and little of certifier			29c. L	icense nur	nber			d (Month, Day,	
		THE STATE OF THE S	MD		0	5 120	15		MARCH	1")!	599
		30. Name and address of person who	1-0 0			NT.	12.00	101	20		
	State	31. Date filed (Month, Day, Year)	32. Registrer's	No KTH Signature	4 L	O. L.	HUSPY.	171	101 1	٥	

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth BELL MORCH 10:20 A.M TIME ARMSTRONG 1999 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Daeth 4c. County of Deeth NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 10 M 2 KF Months Days Hours Yrs. 216-16-3933 JUNE 5, 1924 MARYLAND Usuel Residance of Decedant 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2(No ANNE ARUNDEL SEVERN MARYLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 784 JENNIE DRIVE 21144 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) ADMINISTRATOR U. S. GOVERNMENT 12 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) SMITH MARY SMITH CHARLES 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) LINDALEE C. BEKE (DAUGHTER) 2801 A SAMS CREEK ROAD, NEW WINDSOR, MD. 21776 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 3/15/99 GLEN BURNIE, MD. GLEN HAVEN CEMETERY 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 tagan 23a. Pert1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrast shock, or haart failura. List only one ceusa on each line. Approximate Interval Batween Onset and Deeth immediate Cause (Final OCARDIAL INFARCTION diseese or condition resulting in daeth) day Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Causa (Disaese or Injury that initieted avants resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 2V No 3 Probably 4 Unknown 1 Yes 24b. Wara autopsy findings eveilable prior to completion of cause of daeth? 24a. Was en eutopsy performed? 2 No 1 TYes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) 1□ Yes 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Mannet of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accidant 28f. Locetion (Street end Number or Rural Route Number, City or Town, State) 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0020

requires that the death certificate be executed Attending Physician:

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year)

29a. Cartifier

(Check only one)

29b. Signeture end title of certifiar

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30. Name and address of person who complated ceusa of daeth (Item 23e) (Type, Print)

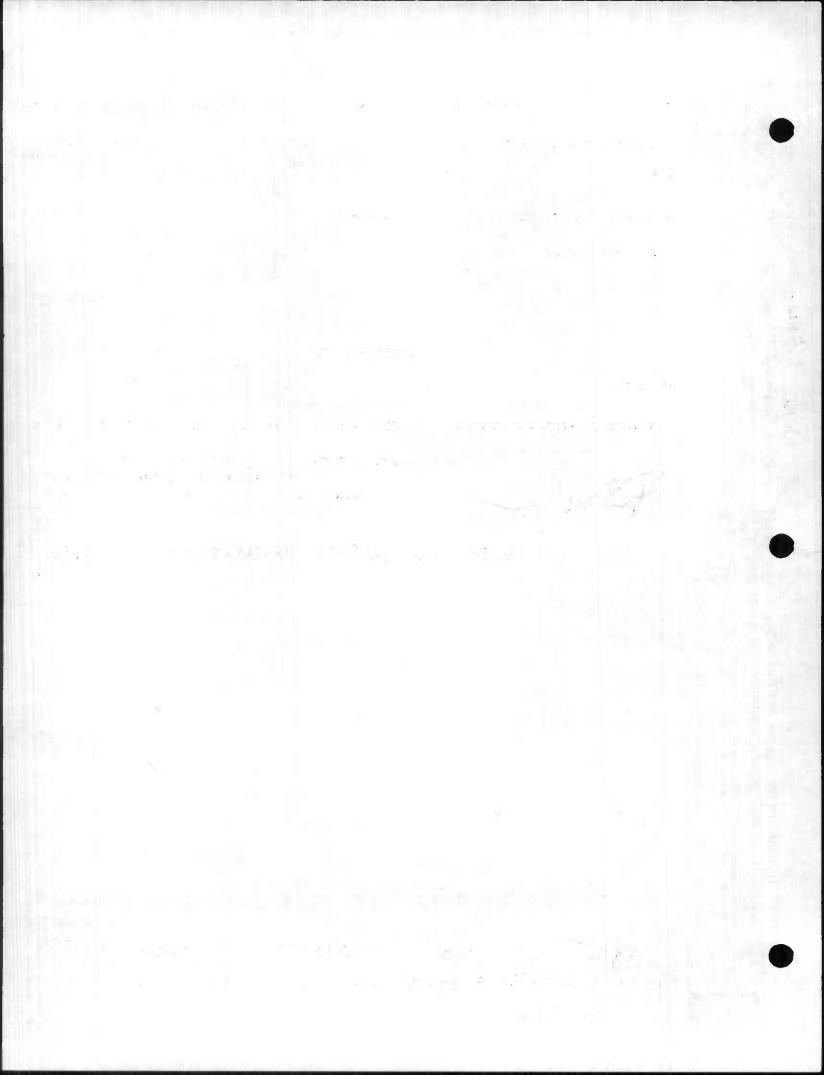
7. 301 Hospi 32. Registrer's Signature

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29c. License number

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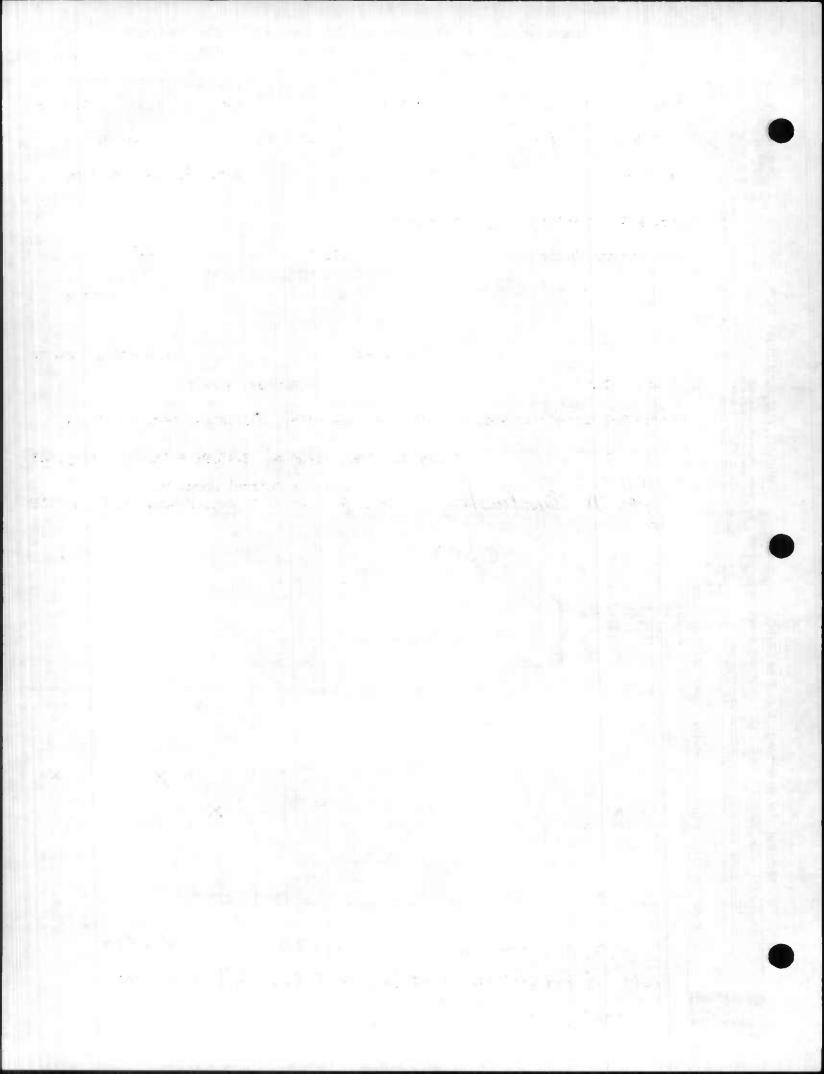
29d. Date signed (Month, Dev. Year)



State of Maryland / Department of Health and Mental Hygiene 9 08050

	Certificate of Death	Re	g. No.				
West Charles	Decadent's Name (First, Middle, Last)	2. Dete of Deeth Month		3. Time of Deeth			
Physician /Medica	POLITE POSCIBORACE	March 12	2, 1999	5:00 am			
Examiner	4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Lo 1939 Newhaven Drive Baltimore		4c. County of Deet Baltimor				
Funeral	5. Sociel Security Number 6. Sex 7. Age (In vrs. lest birthdey) If Under 1 Year If Under 24 Hrs.			hplace (Stete or Foreign untry)			
Director	216-42-6617 Usuel Residence of Decedent	Jan. 31,1944 Maryland					
Maryland	10a. Stete 10b. County 10c. City, Town or Location Maryland Baltimore Baltimore			10d. Inside City Limits 1 ☐ Yes 2 No			
th with the Ma 23s or 28s-fs	10e. Street end Number 10f. Zip Code 1939 Nehaven Drive 21221	10	Og. Citizen of What Co	t Country?			
and 21215-0020 be filed within 72 hours efter death with the Maryland niel Hygiene. Id other than "natural", or frems 23s or 28s-f show event, the Mod Cas Examiner must be notified at the Commission by Engage Infraction	3 □ Widowed 4 □ Divorced Year or Detes:	ecify Yes or No- Rican, etc.)	14. Race - Ame Bieck, White Specify:				
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laryla 2 should lend Man end Man is marke aumatic	19a. Informent's Name/Raletionship (Type, Print) 19b. Mailing Address (Streat and Number or Run			Zip Code)			
Health eight com 27 is	George Bodenschatz (husband) 1939 Nehaven Drive, Ba	ltimore,	Maryland	21221			
Baltimore, Maryle bernit. Pages 1 and 2 should Depertment of Health and Mar Important: If item 27 is marke any Injury or other traumatic	20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Holly Hill Mem. Gardens	me of Dete 20c. Location - City or Town,					
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2 5 5 5		24e. Wes en perform	ned?	Wara autopsy findings eveilabla prior to completion of cause of deeth?			
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Division of Vital Rec To the Hospital or Attending Physician: The lew within 24 hours after death. To the Funersi Director: After this certificate has the completely filled in by the funeral director, page 2 s	1 Yas 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	28d. Describe hor	nce 6 Other (Spe w injury occurred				
To the Hospital or within 24 hours aft to the Funersi Di completely filled in							
the H thin 24 of the F mplete							
O N N N	220. Significative and the discontinuous of the control of the con	9c. License number 29d. Dete signed (Month, Dey, Year) 3/12/99					
	30. Name end eddregs of person who completed cause of deeth (Item 23e) (Type, Print) Scott A PRESET AD 21/2 Dundalk Ave	BaHima	M MD				
State Registrar	31. Data filed (Month, Dey, Year) 32. Registrer's Signature 4. South						

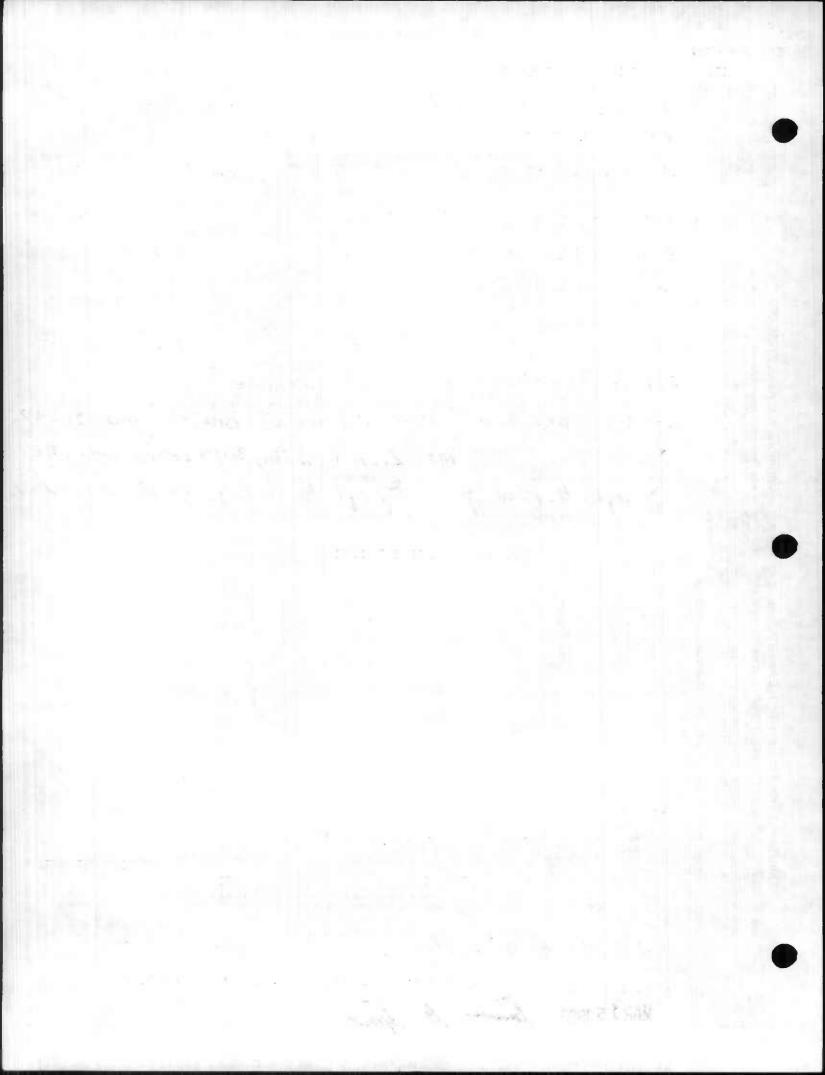
DHMH 16 Rav 6/95



HAROLD BRAXTON	State of Maryland / Department of Health and WR wR PART I, 27, 28A-F PER MEO G769 3-16-99 Certificate of Death	i Mental Hygi	eneg 9	8051	
Physician	1. Decedent's Neme (First, Middle, Last) HAROLD Edward BRAXTON	2. Dete of Deeth Month MARCH 9	Dey Yeer	3. Time of Death 1.320 PM	
/Medical Examiner		or Location of Deeth	4c. County of Dec	əth	
Funeral Director	120 74 8252 12 38 Yrs.	Irs. 8. Dete of Birth (Morth, Day,	9. Bi	rthplece (State or Foreign Country) M C	
he Maryland 28a-1 show corried at	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location R A R B L I MORC			10d. Inside City Limits 12 Yes 2 □ No	
th with the Ma 23a or 28a-1s unt be notified	10e. Street end Number 10f. Zip Code 2/202		10g. Citizen of What Country? U - 5 , A		
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1 21215-005 ed within 72 hours ygiena. Per then "natural; nt the Medical Earl Completed by	15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) V 16e. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use ratired) E L C C R I C I R N	working 1	6b. Kind of Businas	CP LE	
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at benaminent of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or myniqury or other traumatic event, the Medical Examinate. To Be Completed by F	17. Father's Neme (First, Middle, Last) ARTHUF BRAXTOW 301 18. Mother's ELA,	Neme (First, Middla, M	e (First, Middla, Maidan Sumama)		
re, Maryle 1 and 2 should Health and Mer ism 27 is marke other treumstic	19a. Informent's Name/Raletionship (Type, Print) MARGIE BRAXTON 19b. Mailing Address (Street and Number or 850 HI/MAN C	T BALT	me me	1 21202	
Baltimore, Moemit. Pages 1 and 2 operation of Health important; if tem 27 1 and 27 1	20e. Method of Disposition 12 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)	7 3/15/99 L	20c. Location - City of AND dods	work of Md	
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Physician /Medical	23e. Part 1. Enter the disease, or complications that caused the death. Do not arrive the mode of dying, such as care shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALCHO) AND NADCOTTO INTOVICATION	liac or respiretory erre	st,	Approximete Intervel Between Onset end Death	
Examiner	disease or condition resulting in death) ALCHOL AND NARCOTIC INTOXICATION Due to (or es e consequence of):				
Box 68760, eath certificata be axecuted attending physician and I for use as the burial-transit clan/Medical Examiner	Sequentielly list conditions, if any, leading to immediate ceusa. Entar Undarlying Cause (Disaase or Injury that intileted events resulting in death) Lest b. Due to (or es e consequence of): c. Due to (or es e consequence of):				
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of Vital Records, Physician: The law requires the this certificate has been signed rail director, page 2 should be		24e. Wes er perform		. Were eutopsy findings eveilable prior to completion of cause of daath?	
Vital Recipion The law certificate has rector, page 2.	25. Was case referred to medical 26. Place of	128 Ye	s 2 No	1ÆYes 2□ No	
of Vita Physician: this certificated in To Be (axaminer? ↑Control No Hospital: 1 Inpatiant 2 Dept/Outpatient 3 DOA Othar: 4 Nursin	g Home 5 Resida	nca 6 □Other (Sp	ecify)	
sion anding ath. v: Aften ha fune	1 Neturel 2 Accident 3 Suicide 4 Homicida 5 Panding investigation 6 Could not be datamined 5 Panding investigation 6 Could not be datamined 6 Record not be building, afc. (Spacify)	UNKNOWN 28f. Location (Str. City or Town	reet and Number or	PHESTONUESP.	
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To the within 2 To the compla	29b. Signeture end title of cartifier Atyph A Vaclop MP 29c. License number 0.C.M.E.		9d. Date signed (Mo MARCH 10,		
2000	30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Strphyn S, Radente 111 Penn Street, Baltim 31. Date filed (Month, Day, Year)	ore, Maryl	and 21201		

Registrar

MAR 1 5 1999 Server B. Sports



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death MARCH 1999 Charlene L. Butler 3:00 pm 4c. County of Death 4a Facility Nama (If not institution, giva street and number, 4b. City. Town, or Location of Death BURNIE ARUNDE If Under 1 Year If Under 24 Hrs Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 10 M 20 F 37 214-90-6913 3, 1961 Md Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 XXXO Anne Arundel Glen Burnie 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7971 Covington Avenue 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas 2 ☐ No If Yas, Give 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify Specify: Black 3 ☐ Widowad 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Protocal Dept. of Defense 12th Grade 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) Charles L. Coleman Elizabeth Steward 19a. Informant's Name/Ralationship (Type, Print) Husband 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Lionel R. Butler 7971 Covington Avenue Baltimore, Md. 21061 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Crametion 3 Removal from Stata 4 Donation 5 Othar (Specify) March 13Elkridge, Md. Meadowridge Cemetery 22. Nama and Address of Facility Nutter Funeral Homes, Inc. 21 Signature of Funeral Service Licenses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 nuller 23e. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediata Causa (Finel disaase or condition resulting in death) Dua to (or as e consequence of): anemia Severe Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last C encephalo path Dua to (or as a consequence of): Shock Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pulseless tailure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 Yas 2 No 1 ☐ Yes 25. Was casa refarred to medical axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manylar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 ☐ Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homloide

or Attending Physician: The law requires that the death carlificate be axecuted Box 68760. P.O. Records, Division of Vital

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

Md.

Funeral

Director

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Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than inly injury or other traument.

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Medical Certification: To

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72 hours aftar

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Registrar

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ed cause of deeth (Item 23a) (Type, Print)

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2. Registrar's Signatura

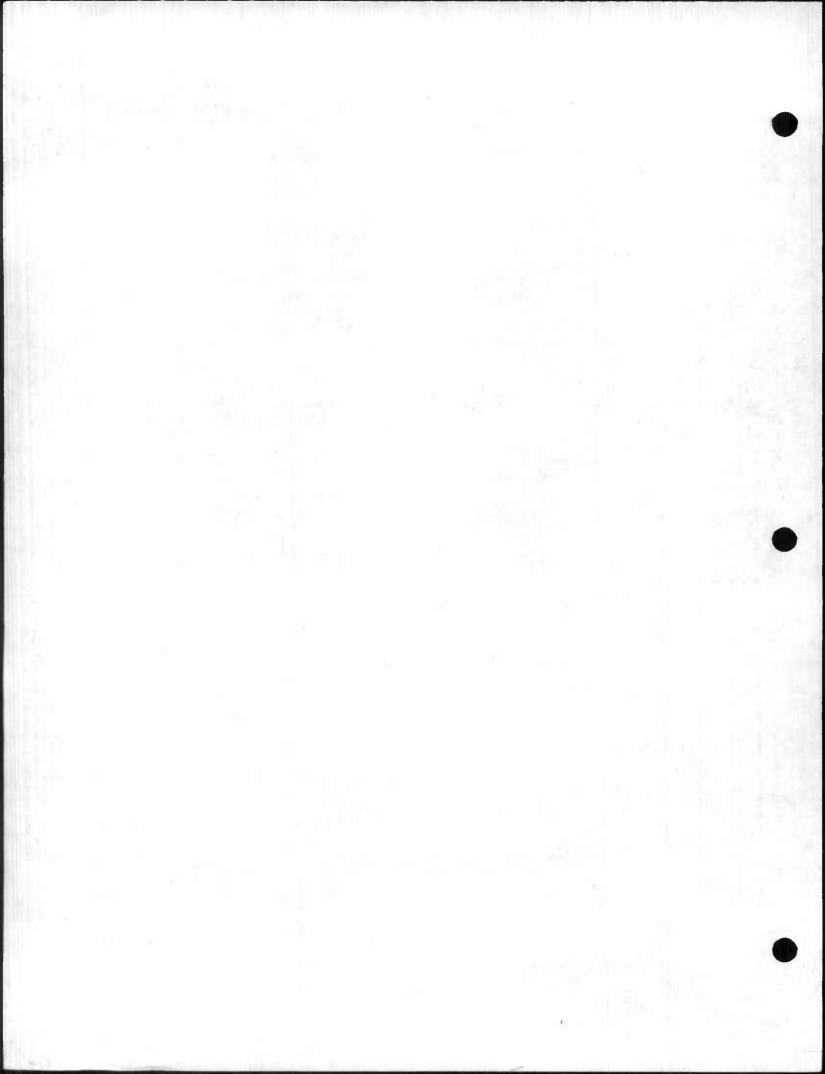
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

blical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Monte, Day, Year)

Glen

29c. License number



Please Type or Print In Black Indelible ink. Assure All Coples Are Legible. Item: 20b per F.H G-769 3/30/Stafe of Maryland / Department of Health and Mental Hygiene. Item: 31 per V.R 3/15/99 reb Certificate of Death (Decedent's Name (First, Middla, Last) 3. Time of Death 2. Date of Deeth **Physician** Dreese 25/25 U: 25am March /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 0+ Baltimore Maryland Medical University If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 2 F 218-26-8883 64 March 15, 1934 MD. Usual Residence of Decedent 10e State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 € No Baltimore Lochearn Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number Apt. 609 6800 Liberty Road 21207 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 (17) Yes 2 □ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Married 2 Married 1 ☐ Yes 2 NO Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT usa retired) 16h Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Public Relations-Writer Self-Employed 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fether's Neme (First, Middle, Last) Wayman Breese Gertrude Holmes 19a. Informant's Name/Raletionship (Type, Print) wife 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 6800 Liberty Road Baltimore, Md. 21207 Apt. 609 Shirley Breese 20b. Plece of Disposition (Nama of Cedar Hill cometary, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 14 Buriel 2 Cremetion 3 Removal from Stete Memorial Cemetery March 15 Brooklyn, Md. Baltimore MC 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signeture of Funerel Service Licenses ع 2501 Gwynns Falls PKWY Baltimore, Md. 21216 neitter 23a. Part1. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Entar Undarlying Ceuse (Diseese or Injury that initieted events eloma resulting in deeth) Lest 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 2 No 3 Probably 4 Unknown 1 Yas þ 24b. Were autopsy findings eveileble prior to completion of cause of daath? 24e. Wes en eutopsy performed? Completed 1 TYes 2 No 25. Was casa referred to medical examiner? Be 26. Placa of Daath (Chack only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 2 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? Certification: Neturel 5 Panding 1 Tyes 2 No investigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide

and I-transit The law requires that the death certificate be axecuted attending physician a for usa as the burial-Division of Vital Records, P.O. Box 68760, signed by the a ils certificate has I director, paga 2 s or Attending Physician: this After To the Hospital or Attending within 24 hours aftar death. To the Funeral Director: Afta completely filled in by the fun

Funeral

Director

"natural", or items 23a or 28a-f ahow edical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours aftar death v Department of Haaith and Mental Hyglena. Important: If item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Medical Exam her must bodge.

Physician

/Medical **Examiner**

with the Maryland

Registrar

State

edical

funeral

FASSAS MP 31. Dete filed (Month, Day, Year)

29b. Signature end title of certifier

29a. Cartifiar

(Check only one)

32. Registrer's Signeture

30. Neme and eddress of person who complated causa of daeth (Item 23e) (Type, Print)

1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner stated.

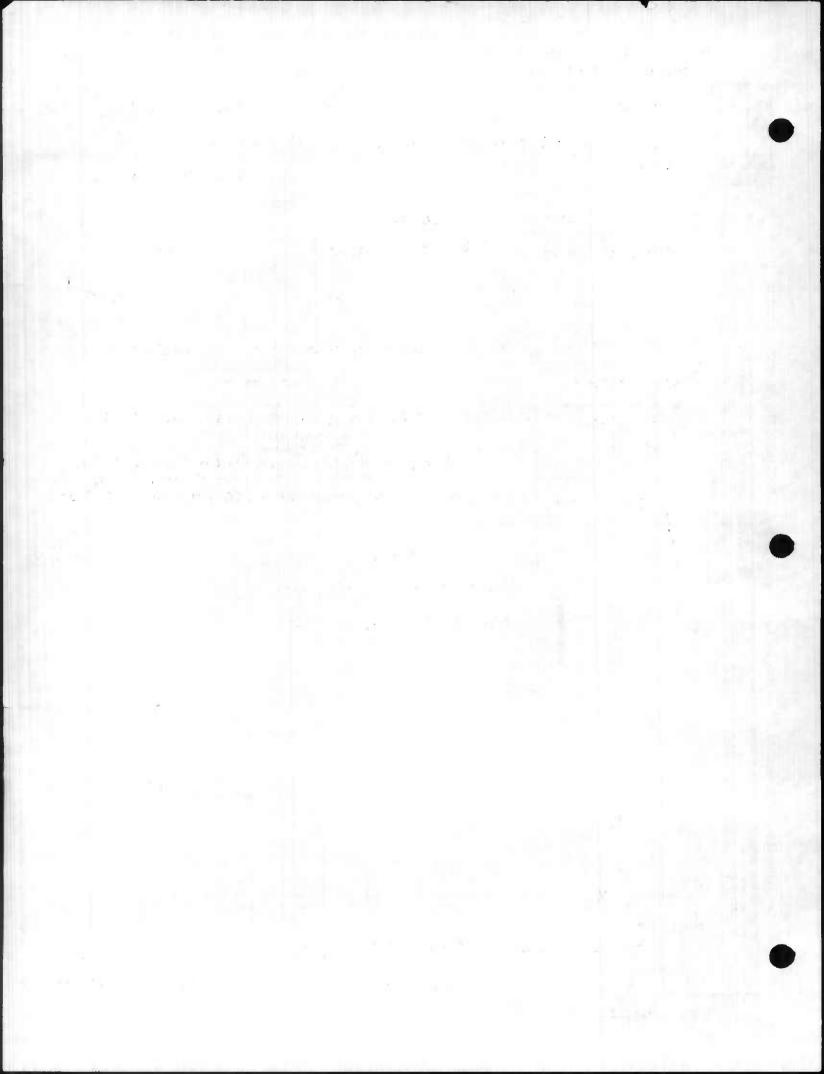
00 528 36

Greene St. Baltimore, Ud. 21201

29d. Date signed (Month, Dev. Year)

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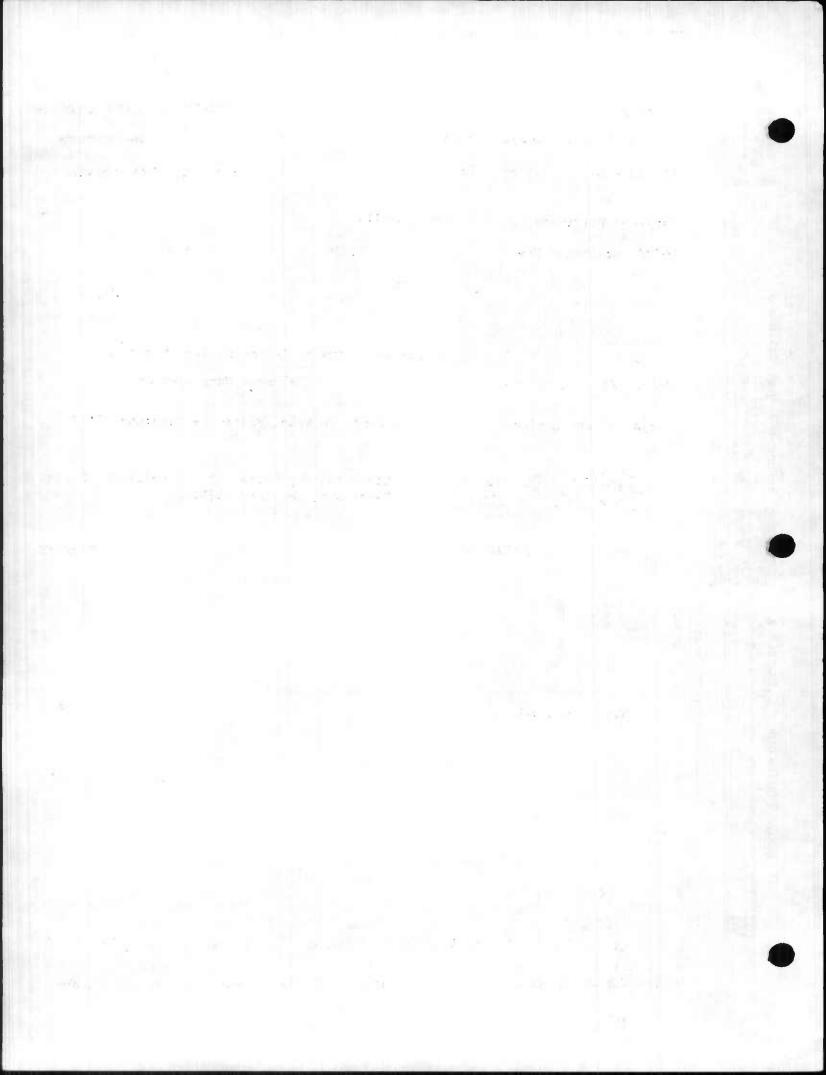
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Time of Deeth Day Month **Physician** 5, 1999 Peggy Cook MARCH 6:00 AM /Medical 4a Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore If Undar 1 Yaer | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Deys Hours Min 1 M 2 F Yrs. 75 214-20-8784 Sept. 13, 1923 Maryland Director Usual Rasidance of Dacedant I be filed within 72 hours efter death with the Maryland ntal Hygiene. ad other than "naturel", or Rema 23a or 28a-1 ehow event, Ital Madical Example; must be notified at 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ₩ No Directo Cockeysville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 21030 U.S.A. 10707 Cardington Way Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - Amaricen Indian. 11. Merital Status Black, Whita, atc. 1⊠ Nevar Married 2 Married Specify: White 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Represenative Electric 5+ 12 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be finent of Health and Mental Hint: If Item 27 is marked of Margaret Mary Wickham Joseph Stanislaus Cook 19b. Mailing Address (Streat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 7031 Kenleigh Road, Baltimore, Maryland 21212 Margaret Berman/niece important: If Item 2 eny injury or other 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 □ Burlal 2 □ Cramation 3 □ Ramovel from Stata 4X Donation 5 ☐ Othar (Specify) 21. Signature of Fune al Service Licenses Rope 1 S. Wade, 23 Partend Address of Bylliboard, 655 W. Baltimore Street Director Baltimore, Maryland 21201 BATILIHOLE, PLAT Y LARGE 21202

Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, or heart failure. List only one cause on each line. Approximata Intervel Batween Onsat and Death **Physician** /Medical Immediata Causa (Final PNEUMONIA 8 DAYS disaasa or conditior rasulting in daath) Examiner Dua to (or as a consequence of) Physician/Medical Examiner physician end the buriei-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immediate ceusa. Entar Undarfying Ceuse (Diseese or injury that Initieted events resulting in death) Lest Due to (or es a consaguence of): Division of Vital Records, P.O. Box 68760. Dua to (or as a consequence of) 50 ettending esn signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown MYELODYSPLASIA p 24b. Wara autopsy findings evailable prior to been si 24a. Was an autopsy Completed complation of cause of death? is certificete hes director, page 2 1 Yas 2 No 1 ☐ Yas 2 No Attending Physician: 25. Was cesa rafarrad to medicel axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funerai 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 1 Natural
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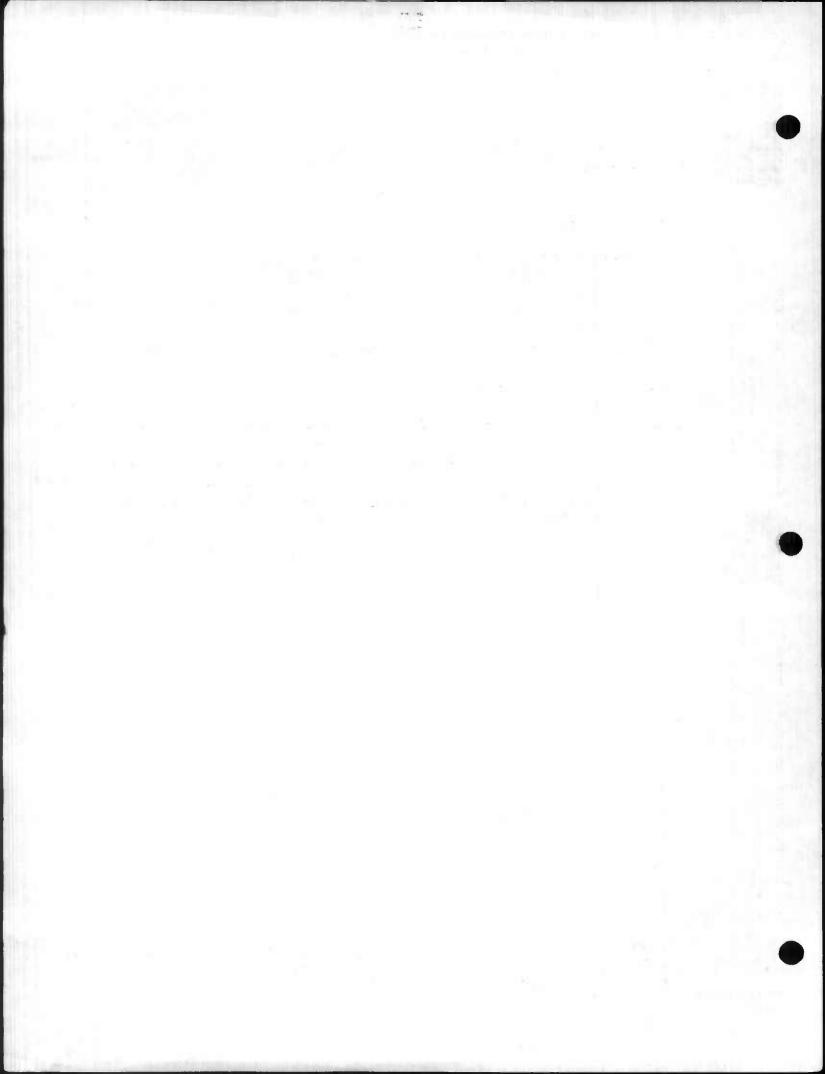
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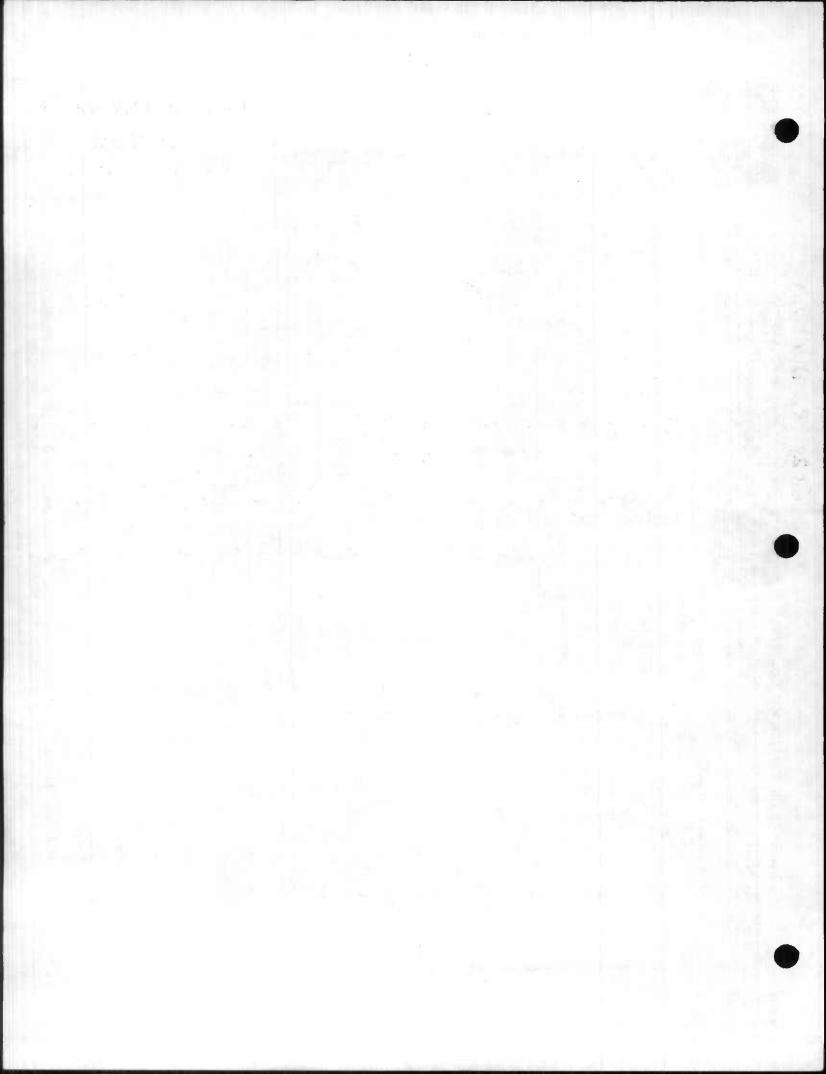
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Funeral Director		5. Social Security Number 220-64-5125	6. Sax 1 M 2 F 7. Ag	a (In yrs. last 44	Yrs. Mont	der 1 Year hs Deys	Hours Mir		ay, Year) 9-54	Coun	leca (Stata or Foraigr htry) 1D		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Month Dey Year Year Year

		Certificate of Death	Reg. No.	00000
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Physician /Medical	Cozy L. Durham		march 11 1	999 12'5 pm
Examiner	4a Facility Neme (If ngt Institution, give street end number)	4b. City, Town, or Lo	/	0 1
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Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. k	est birthday) If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
Director	Usual Residence of Decedent		July 5, 1913	North Caroling
Jend Man		, Town or Location		10d. Inside City Limits
filed within 72 hours efter deeth with the Maryland Hygiene. Hygiene. Inter than "natural", or items 23s or 28s-f show and, the Mad call Exaction count to incitie 1st and the Mad call Exaction countries. Completed by Funeral Director	MD Harting F	darwood		1 ☐ Yes 2 ☑ No
be notified Director	10e. Street and Number	10f. Zip Code	10g. Citizen of	Whet Country?
23a or 28a-f show ust be notified at al Director	1937 Brookside Drive	21040	0:	SA
r items 234 Alcre rount Funeral	11. Merital Status 12. Was Decedent Ever in U.S Armed Forces?		ecify Yes or No-	ce - American Indian,
Fu Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 Yes 2 No Specify:		ck, White, etc.
l by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Detes:	THE TES ZUENO Specify:	Specif	5 Jack
event, the Medical Examiner must be northed at Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grede completed)	16e. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of B	usiness/industry
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	17. Father's Name (First, Middle, Last)	O 11	e (First, Milddle, Maldell Surlie	7
To	James Leonard	ratt	y Leonard	Chata Zin Cada)
	19e. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Run		1 7 1016
ome	Doris Foreman / Niece 20e. Method of Disposition 20b. Pl	ace of Disposition (Name of	Date 20c, Location	- City or Town, Stete
o o	1 Burial 2 Cremation 3 Removal from State	metery, cremetory or other plece)	1.00/00	
any Injury or once.	4 □ Donation 5 □ Other (Specify)	1t. Con Cemetery 1-	4	more, MD
any l	21. Signature/of Funeral Service Lograge	22. Name end Address of Facility Hari P. Gose F	ineral Service	e
	At the	1701 McCulloh St	., Balt., MD	
	23a. Part1. Enter the disease or complications that caused the death shock, or heert failure. List only one cause on each line.	. Do not enter the mode of dying, such es cardiac	or respiretory arrest,	Approximate Intervel Between
sician	1. 20	A.		Onset end Deeth
ledical aminer	immediate Cause (Final disease or condition resulting in deeth)	as wear or	scarce.	Har
		es a consequence of):		
iel-transit Examiner	b			
EXa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	es a consequence of):		
<u>a</u>		es e consequenca of):		
es the	resulting in death) Last	es a consequence or.		
0 2	d			
d for	Part II. Other significant conditions contributing to death but not seen	Iting in the underlying cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death?
be detected for us by Physician/	C	aluare	1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
by P	Correctly alley	O Co		
leted	()		24a. Was en autopsy performed?	24b. Were autopsy findings available prior to
Completed			periorities	completion of cause of death?
mo			1 ☐ Yes 2 🕶	1 ☐ Yes 2 No
BeC	25. Was case referred to medical	26 Piece of Dea	th (Check only one)	
To B	examiner?	Other:	ome 5 Residence 6 Ott	her (Specify)
	27. Menner of Deeth 28e. Dete of Injury	28b. Time of 28c. Injury	28d. Describe how Injury occu	
ation	1 Natural 5 Pending (Month, Day Year)	Injury Work? M 1 Yes 2 No		
d in by the l	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At hor building, etc. (Specify	me, farm, street, fectory, office	28f. Location (Street and Num City or Town, State)	ber or Rurel Route Number,
ed in by the funera Certification:	building, etc. (Specify,	,	Only or Town, Olator	
Sal	29s. Certifier 11 Certifying Physician: To the best of my know	rledge, deeth occurred at the time, date end plece,	and due to the ceuse(s) end m	enner as stated.
pietely fill edical	one) 2(1 Medical Examiner: Chitra has of examinati	on end/or Investigation, in my opinion, deeth occur	red at the time, date and piace,	, and due to the cause(s)
completely filled in	29b. Signature and title of certifier	29c. License number	29d. Date sign	ed (Month, Dey, Year)
	1 Hab aTralic	×. D28339	7 March	12, 1999
1	30. Name and eddress of person who completed cause of death (Item	23e) (Type, Prim)	0000	1440
d	LINDA FREILICIT I	of o wheel 14	nd Belle	14021015
State	31. Date filed (Month, Day, Year) 32. Registrer's Signat			
Registrar	MAR 1 5 1999	D. Cosskal		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 22 per F.H G-769 3/15/99 reb 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath MARCH EVANS WOODROW 10,1999 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Baltimore Rehabilitation, + Extended Care Baltimore NA 5. Social Sacurity Number 6. Sax If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1 M 2□ F Days 84 243-18-2531 January 10, 1915 Usual Rasidance of Dacadant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Myas 2 No MD NA Baltimore 10e. Straat and Number 10g. Citizan of What Country? 12. Was Dacedant Evar in U.S. 2914 Ave 21216 U.S. A 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian, Black, Whita, atc. Amed Forcas? 1 Avas 2 No If Yas, Giva 1 Navar Married 2 Married 1 Yas 2 No Spacify: 3 ₩idowad 4 Divorced Yaar or Datas: WW IL Black 15. Dacedant's Education 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry (Spacify only highast grada complated) Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Farmer Farming 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) red Evans Millie Young 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Pauline 20b. Place of Disposition (Nama of comatany, cramatory or other place) Data 20c. Location - City or Town, Stata Jar man SISTEY 20a. Mathod of Disposition Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Falling Run Ch. Cematery 3/18/99 Fayetteritle, 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signal ra of Funaral Sarvice Licensaa 22 Name and Address of Facility James A. Morton Sons F.S F.H. & num 1701 Laurens St. Balto., or haart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final Domentia 4 years disaasa or condition rasulting in daath) Dua to (or as a consequance of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown basilar artery insufficience 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of causa of death? 1 Yas 2 NO

Physician /Medical Examiner

The law requires that the death certificate be executed

After this certificate has

Be

Certification: To

Medicai

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Division of Vital Records, P.O. Box 68760,

pernit. Pages 1 end 2 should be filed withir Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than any injury or other traumetic event, the Me

Physician

/Medical

Examiner

10a Stata

Funeral

Director

in "natural", or items 23a or 28a-f show Medical Examiner must be notified at

filed within 72 hours after deeth

Baltimore, Maryland 21215-0020

Director

Completed by

Be

Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaase or injury that initiated evants rasulting in daath) Last þ Completed

Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. Hypertension, Syncope

26. Place of Death (Check only ona)

1 ☐ Yas 2 ☐ No

25.	axaminar?		to medical
	1 🗌 Yas	2[] No	
27.	Mannarof	Death	

1 ☐ Inpatlant 2 ☐ ER/Outpatiant 3 ☐ DOA 28b. Tima of

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

(Check only onel

1 Natural

2 Accidant

3 Sulcida

4 T Homicida

1 Certifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

29b. Signature and title of certifier

5 Panding invastigation

6 Could not be datarmined

D32548

29d. Data signed (Month, Day, Year) March 10,1999

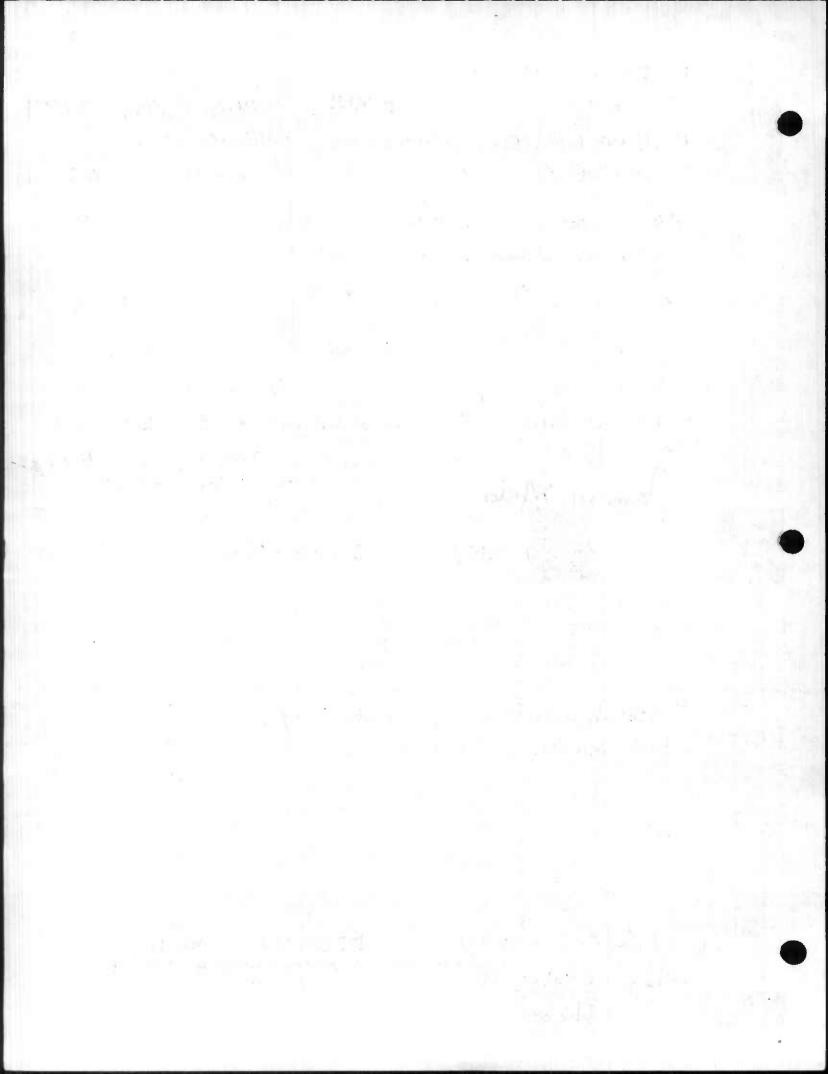
30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) (O North Freene Baltimore

Registrar

31. Data filed (Month, Day, Yaar) MAR 1 5 1999



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Funeral Director

28a-f show

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Items 23s

'natural', or

The Medical

Important: If Item 27 is marked other any injury or other traumatic event. It

Baltimore, Maryland

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Pages 1 and 2 should

Health and Mental

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Physician /Medical

Examiner

ician end burial-trensit

physician s the burial

been signed by the attendin should be deteched for use

page 2

this

After

death.

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu

funeral

98

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

Examiner must be notified at

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legib	
State of Maryland / Department of Health and Mental Hygiene	\cap

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month 3. Tima of Death Yaa **Physician** Wesley D. Edwards 1999 MARCH 8 1:50AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Birthplaca (Stata or Foreign Country)
 New York 10XM 2□ F Days Hours Min. Yrs 074-16-8721 77 Aug 8 Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Baltimore **Timonium** 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2400 Broad Avenue 21093 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 XYas 2 □ No If Yas, Giva Yaer or Datas: WW Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Navar Married 2 Married 1 ☐ Yas 2 X No Specify: Specify: White ρ 3 Widowad 4 Divorced WW II Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) 12 3 Logistical Engineering Writer Defense 17. Fathar's Nama (First, Middia, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be Alexander Dubinsky Rose Vorona 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Lois Virginia Kemp Edwards/Wife 2400 Broad Ave., Timonium, MD 21093 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 3/12/99 ata 1 X Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata Dulaney Valley Memorial Gardens Timonium, MD 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility Lemmon Funeral Home 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximately 10 W. Padonia Rd., Timonium, MD 21093

Approximately 10 Padonia Rd., Timonium, MD 21093 Approximate Interval Batween Onsat and Death Immediata Cause (Final disaasa or condition rasulting in deeth) Examine Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Be Completed by Physician/Medical onhodokins ly Part II. Other significant conditions contributing to death but not 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performad? 28 NO 1 🗆 Yas 1 ☐ Yas 20 No 25. Was casa rafarrad to medical axaminar? 26. Place of Death (Chack only ona) 1 ☐ Yas 2 No Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) Certification: To 1 Inpatiant 2 ER/Outpetlent 3 DOA 27. Manner of Death 1 Whatural 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be datamined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and manner stated. 29a. Certifiar Medical (Check only one)

State Registrar

29b. Signatur

Ruth Kantor, M.D. 31. Data filad (Month, Dey, Year) 1999 **MAR 15**

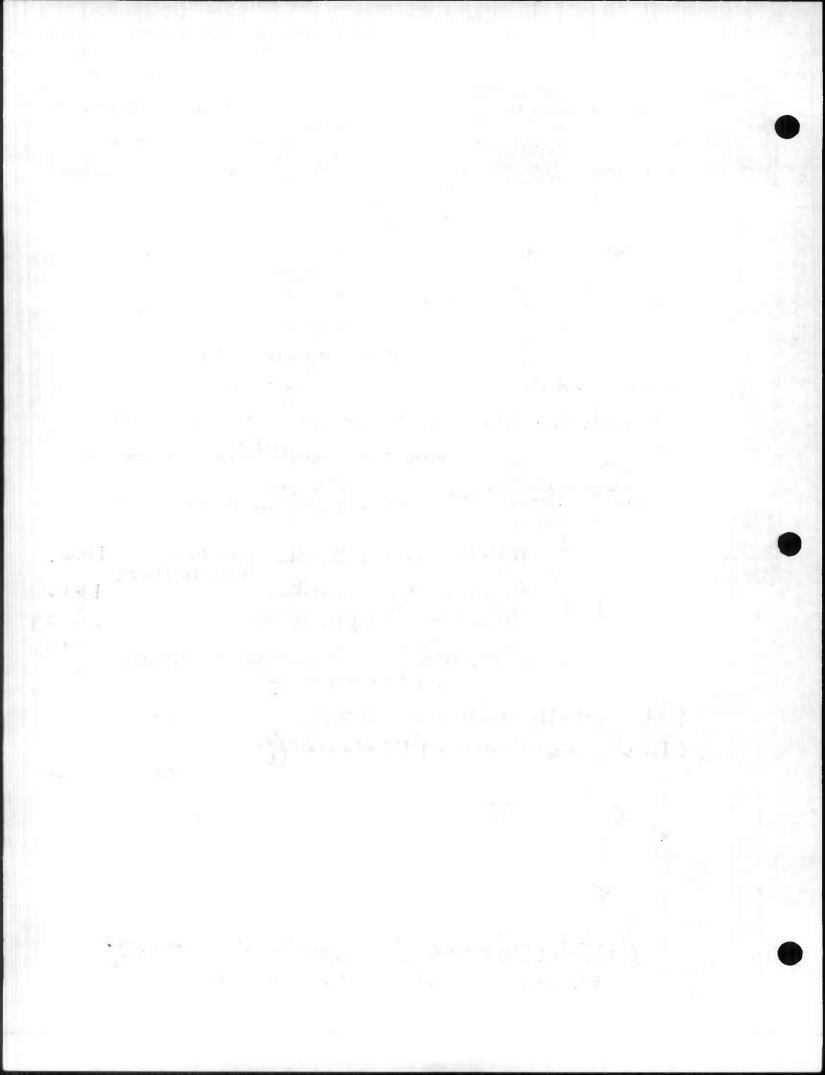
30. Name end eddrass of person who completed ceusa of death (Item 23e) (Type, Print)



29c. Licansa number

6701 N. Charles St., Towson, MD

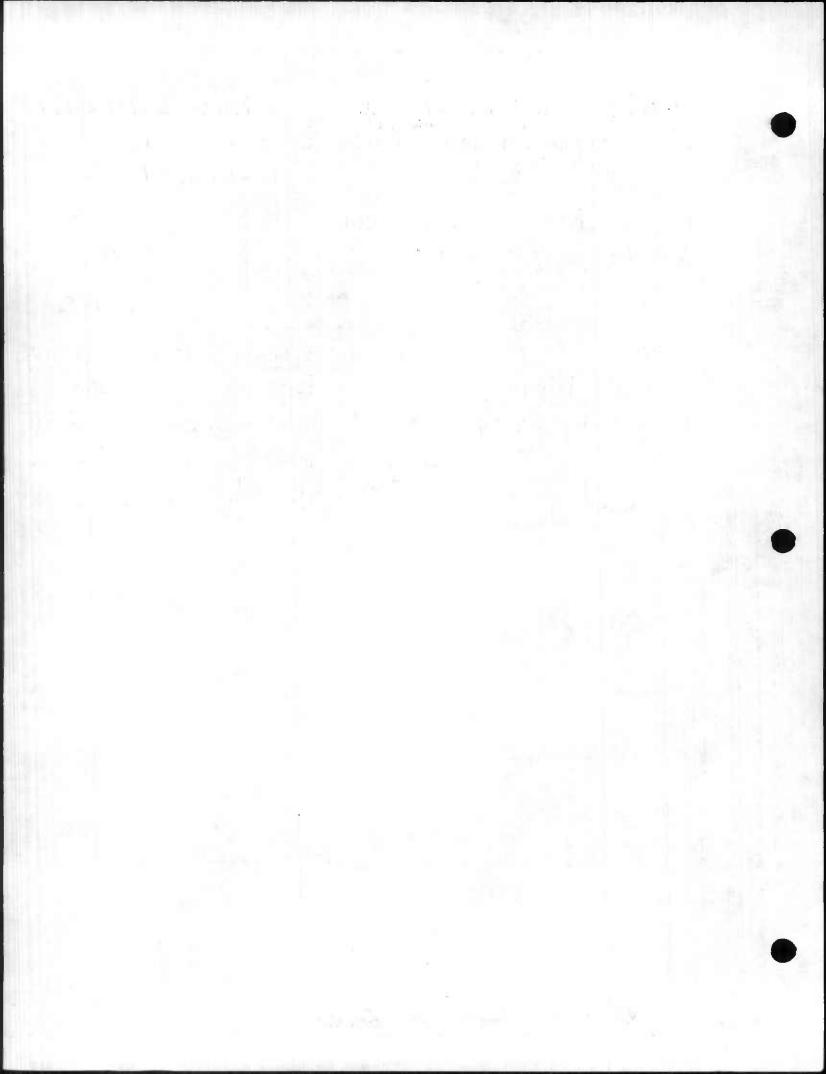
29d. Data signad, (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Neme (First, Middle, Last 2. Date of Death **Physician** larc /Medical ility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of C Examiner Hopkins enter If Under 1 Year Geriatr 0 TIMOTE John S 7 5. Social Security Number ff Under 24 Hrs 8. Dete of Birthplece (State or Foreign /Gountry) 7. Age (In yrs. last birthday) **Funeral** -4676 Months Deys 10M 20 F Hours Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits If Item 27 is marked other than "naturel", or home 23a or 28a-f ahow or other traumatic event, the Hedical Examinar must be incurred at Maryland 1 Yes 2 □ No Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 2 STOWN Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -Race - American Indien, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours after Hygiene. 1 Never Merried 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health end Mental Hygiens in mortant: if fem 27 is marked other than "naturel", or any injury or other traumatic avant Saltlmore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) omestic 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be tende nne sor 19e. Informati's Neme/Relegionship (Type, Print) (515ter 19b. Meiling Address (Street end Number or Rural Route Number. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date Mem. Garden 1 ⊠ Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Joseph L. KU ZZZZ W. Nor 21. Signeture of Funeral Service Licensee Funera Ave. W. North Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** respiratorn /Medical Immediate Cause (Final disease or condition resulting in deeth) arrest 2min Due to (or as e consequence of) COPD Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury the initiated events resulting in deeth) Lest Due to (or es a consequence of): and physician Box 68760. Physician/Medical tha Due to (or es a consequence of): 980 Pert fl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Vunknown by 24b. Ware eutopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? has 1 Yes 2 No 1 Yes 219 No Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Director: After 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 PNeturel 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 1000 MD D 0054067 March, 13, 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 24 Geriatrics CEV 5505 JH Bayview Circle Battimore MD 21224 YASAR 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Beatrice Franza March 12, 1999 3:15 AM 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Liberty Medical Center Baltimore 8. Dete of Birth (Month, Day, Year) Dec. 23,1931 If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 9. Birthplece (State or Foreign Country) Illinois 7. Age (In yrs. last birthday) Days Hours Months 1 M 2 X X 398-28-9359 67 Usual Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits Yes 2 No Maryland N/A Baltimore 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 2095 Rockrose Avenue 21211 USA 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Merried M∏Yes 2 No frYes, Give 1 ☐ Yes XXNo Specify: Specify: White f Yès, Give Yeer or Dates: 3 ☐ Widowed 4 ☑ Divorced 1951 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Secretary 12 Johns Hopkins 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Earl Kirkbride Beatrice Hedley 19b. Melfing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 21211 19e. Informent's Name/Reletionship (Type, Print) Elizabeth Kreager 1136 Falls Hill Drive Apt B4 Baltimore, Maryland Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Moreland Memorial Park 4 Donetion 5 □Other (Specify) 13/15/99 Parkville, Maryland on of Funeral Service Mony 22. Neme and Address of Fecility Burgee-Henss Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onset end Death chronic elostructure Immediate Cause (Finat diseasa or condition resulting in death) pulmman hea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thef initiated events rasulting in death) Lest amon Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco, use contribute to the cause of death? 1 1 Y68 2 No 3 Probably 4 Unknown gumie 24b. Were eutopsy findings aveilable prior to completion of cause of daath? 24a. Was en autopsy performed? 1□ Yes 2⊞ No 1 Yes 2 LING 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show a notified at

5

Name 23a

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mertal Hygiens. Important if them 27 is marked other than "natural, or than any injury or other traumatic event, the Medical Exemination."

altimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records.

Hospital

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Funeral

Completed

Be

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Physician/Medical Examiner Certification: To within 24 hours after death.
To the Funeral Director: Af
completely filled in by the fu

sician and bunal-transit physician s the buna signed by the at the detached for þ Completed page 2 funeral director, 8 this After

3 Suicide

29a. Certifier

Medical

4 Homicide

25. Wes case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 HNaturat 2 Accident

5 Pending investigation 6 Could not be detarmined

28a. Date of Injury (Month, Day Year)

28e. Plece of fnjury - At home, farm, street, fectory, office building, atc. (Specify)

28b. Time of

28c. fnjury af Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. Licanse number

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29h	Signature	hne	title	of	certifier	
	- g				001111101	

and an

MD

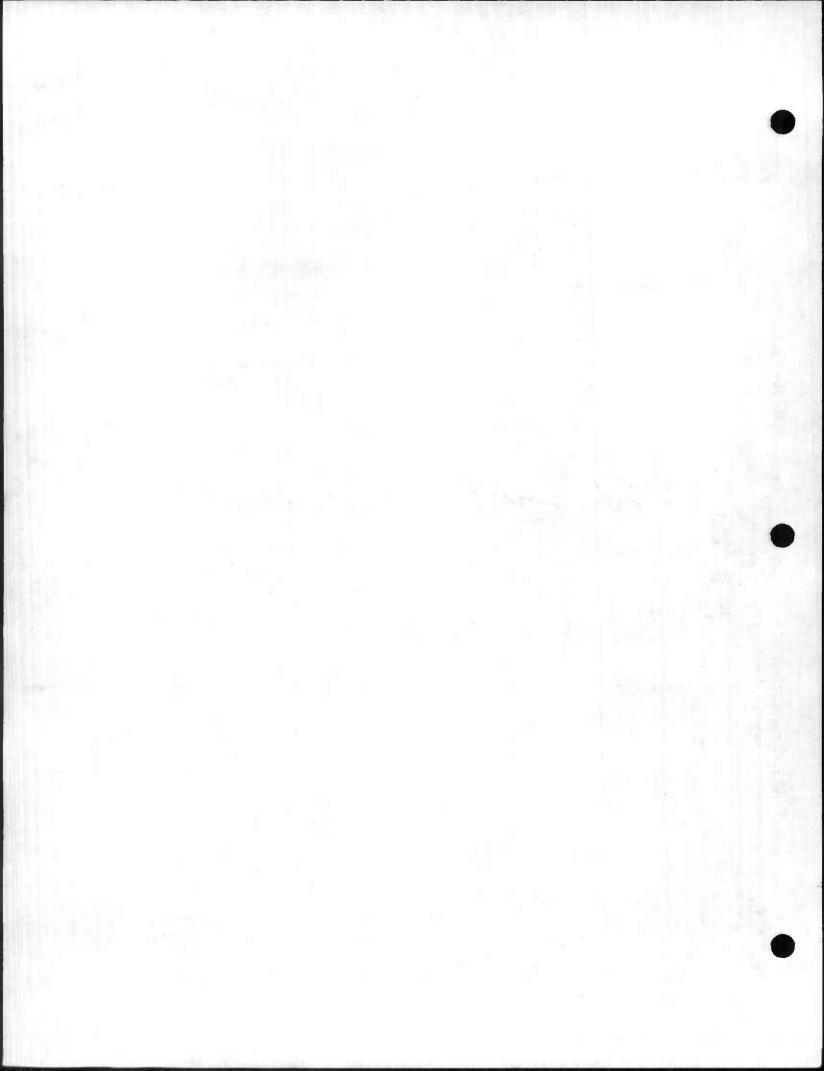
29d. Date signed (Month, Day, Year) 3/12/99

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

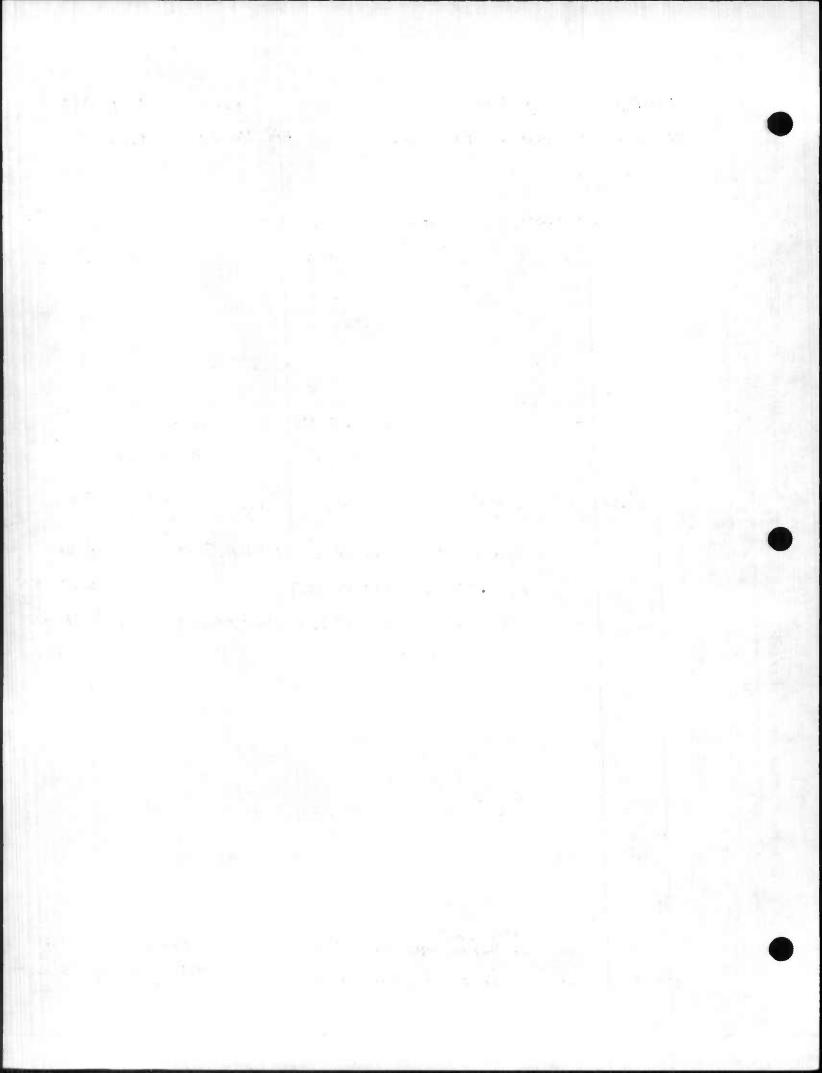
. HASHMI, 521 Entono N.

31. Date filed (Month, Pay, Year) MAR 15 32. Registrar's Signeture 1999

Ff Sonte 30f, Bally . Mys



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Deeth Month Day Year **Physician** MARIE 1999 7:50 Am GLORIOSO MARCH 11 /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER BALTIMORE HOSPITAL HARBOR nla If Under 1 Yeer | If Under 24 Hrs. | 8. Deta of Birth (Month, Day, Year) April4,1918 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Hours Min. Months 1 M 2 F 80 Director Maryland 215-18-9116 Usual Rasidence of Decedent the Meryland 10a Stata 10b. County 10c. City, Town or Location Show 10d. Inside City Limits than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at 1 Yas 2 No Director Maryland Baltimore Baltimore Highlands 10e Street and Number 10f Zin Code 10g, Citizen of What Country? death Funeral 2924 Pennsylvania Ave 21227 States United 14. Race - Amarican Indien, 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. filed within 72 hours after 1 Yas 27 No If Yas, Giva Yeer or Datas: 1 Nevar Merried 2 Married 21215-0020 1 ☐ Yes 2 ☐No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 8 7 is marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name /First Middle Maiden Sumama . Pages 1 end 2 should be fill ment of Heelth and Mental Hant: If Item 27 is marked oth jury or other traumatic even 8 9 Charles White Lena Hale 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 21074 19a. Informant's Neme/Ralationship (Type, Print) 1126 South Main St. Hampstead, Maryland Anna Tusing / Daughter 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Date 20c. Location - City or Town, State XXBurial 2 Cramation 3 Removel from Stete Department Important: I any Injury o Loudon Park Cemetery 3/15/99 Baltimore, Md. 4 Donation 5 Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Ambrose Funeral Home of Lansdowne 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Rd Lansdowne, Md. Approximate tnterval Between Onsat end Death **Physician** /Medical INFARCTION Immediata Causa (Final MYOCARDIAL 1 DAY diseasa or condition resulting in death) Examiner Dua to (or as a consequenca of): Examiner 2 WEEKS BILATERAL PNEWMONIA or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadieta causa. Entar Undarlying Cause (Disease or injury that initieted evants rasulting in death) Lest Dua to (or as a consequence of) pue 3 YEARS CHRUNIC OBSTRUCTIVE PULMONARY DISEASE Box 68760. Physician/Medical the Dua to (or as a consequanca of): 30 YEARQ USB BS HYPERTENSION signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacço use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? page 2 should 1 ☐ Yas 2 ☑ No 1 VYas 2 No certificate funeral director, 25. Was casa rafarred to medical examinar? 8 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) edical Certification: To 1 Yas 2 No 1 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. tnjury at Work? 5 Pending invastigation 1 Netural 1 Yas 2 No within 24 hours after death. To the Funeral Director: A 2 Accidant 8 Could not be detarmined 28a. Placa of tnjury - At homa, farm, straat, factory, offica building, etc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida Hospital 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, data and place, and due to the causa(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. (Check only the th 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signetura end titla of certifier... RESIDENT P 10641 MARCH INTERNAL MEDICUE 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) SOUTH HANOUBR 3001 STREET HOSPITAL CENTER Mon THE HAPBOR BACTIMORE mD 21225 31. Data filed (Month, Day, Year) 32. Registrer's Signerara State 1999 Registrar



Baltimore,

Box 68760

Division of Vital Records, P.O.

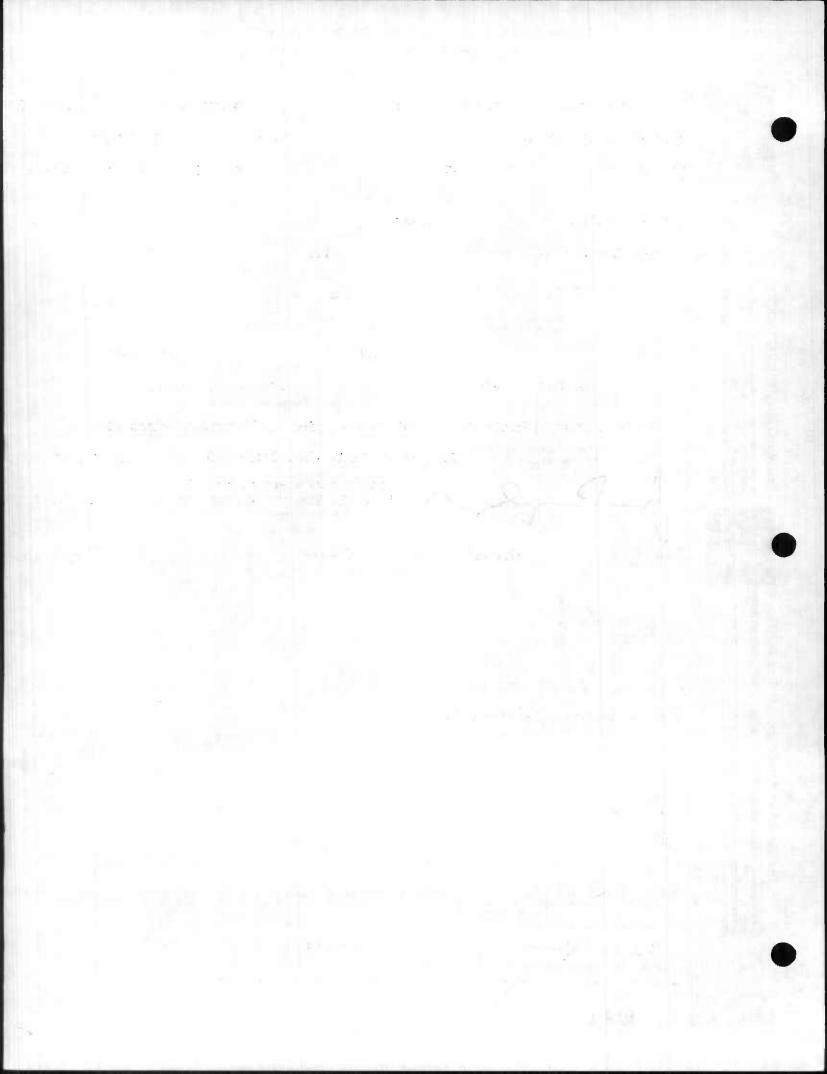
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** March 9, Winifred Goff 1999 Marie 10:15 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** 5 Brett Court # 306 Essex Baltimore 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)
Aug. 14, 1921

9. Birthplaca (Stata or Foraign Country)
West Virginia 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 1□ M 2□ F 77 Yrs 216 24 1603 Director Usual Rasidance of Dacedani with the Meryland 10e Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Modical Examiner must be notified as 1 ☐ Yas 2 ☐ No Directo Maryland Baltimore Essex 10e. Street and Numbe 10f. Zip Coda 10g. Citizan of What Country? 5 Brett Court # 306 21221 USA Funeral filed within 72 hours after death 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian, 11. Marital Status Black, Whita, atc. 1 □ Navar Married 2 □ Married 1 ☐ Yas 200No Specify: þ 3€ Widowad 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) Hygiena. College (1-4or 5+) Elementary/Secondery (0-12) 8 Housewife Own Home permit. Peges 1 and 2 should be file Department of Health end Mental Hy, Important: if item 27 is marked othe sny Injury or other traumatic event, page. 18. Mothar's Nama (First, Middle, Malden Sumema) 17. Fathar's Nama (First, Middla, Last) Cain **Emma** Lester Montgomery 19b. Mailing Address (Street and Number or Pural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 501 Summit Drive Fallston, Maryland 21047 of Disposition (Nama of Data 200. Cocation - City or Town, Katherine Johnson (daughter) 20b. Place of Disposition (Nama of cematary, cramatory or othar placa) 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from Stata Donation 5 Other (Specify) Gardens of Faith Cem. 3/13/1999 Balto. County, Md 22. Nama and Addrass of Facility Bruzdzinski Funeral Home PA 21. Sinatura of Funeral Sarvice Licensaa 1407 Old Eastern Avenue Essex, Maryland 21221 23a Fartt Entar tha disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximete Intarval Batwaan Onsat and Daath **Physiclan** /Medical Immediata Causa (Final disaasa or condition resulting in death) Metastatic Redul 1 years Examiner Examiner The law requires that the death certificate be executed physiclen end the bunal-trensit Sequantially list conditions, if any, laading to immadiate cause. Enter Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Physiclan/Medical Dua to (or as a consequence of) signed by the a Part fl. Other afgniffcant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive Pulnouna Disase à 24b. Wera autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed been has 1 Yas 2 No 2 No 1 Yas After this certificate or Attending Physician: funeral director, 25. Was cesa rafarrad to medicel axaminar? Be 26. Plece of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 ☐ Yas 2 ☐ No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Dascribe how Injury occurred Certification: 28b. Tlma of 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yas 2 ☐ No death. Investigation after death 2 Accident the 6 Could not be detarmined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) illed in by 4 Homicida To the Hospital o within 24 hours af To the Funeral D completely filled i Certifying Physicfan: To the best of my knowledge, deeth occurred et the time, dete end place, and due to tha ceusa(s) and mannar es steted.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end place, and due to the cause(s) edical 29a. Cartifia: and mannar stated. 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifiar 29c. Licansa number 3/11/99 038409 30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) MUNMANT, Med WILLIAM SHMFMAN 4940 ENTIEN 14E 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State porks Registrar



State Registrar

31. Date filed Month, Day, Year) 15

29b. Signature and title of certifier

estance 32. Registrer's Signeture

d address of person who completed cause of death (Item 23e) (Type, Print)

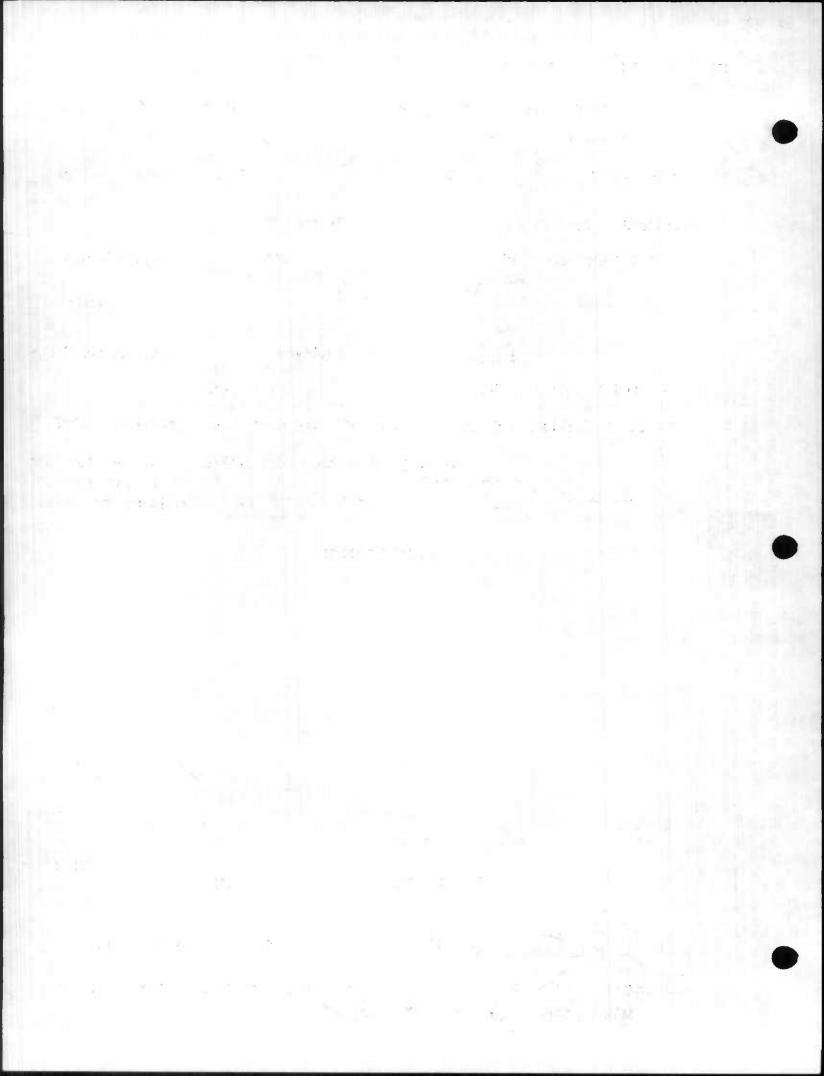
111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

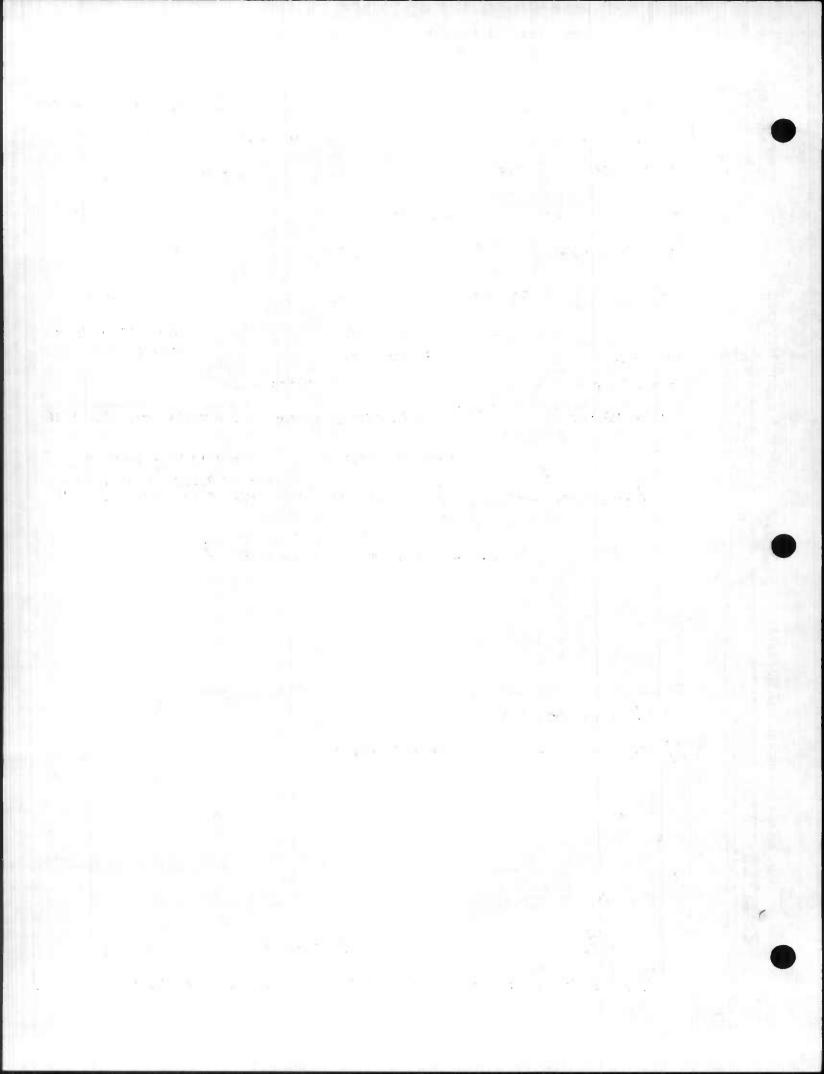
29d. Date signed (Month, Day, Year)

March 14, 1999



State of Maryland / Department of Health and Mental Hygiene ()

Physician	1. Decedent's Name (First, M					2. Date of Dear Month	Day Year			
/Medical Examiner	Ire-e Mucy 4a Facility Name (If not institution, giva street and number)				4b. City, Town, o	r Location of Death	7 99 /Z A:			
- LAGIIIIICI	411 Esdale R	oad			Baltim		n/a			
Funeral Director	5. Social Security Number 219–38–3284	1 □ M 2 💢 📆	Age (In yrs. last birth	day) If Under 1 Year Months Days				9. Birthplaca (State or Fore Country) Md.		
land	Usuel Residence of Decedent 10a. Stata 10b. Cou				10d. Inside City Lim					
r 28a-f ehow	Md.	n/a	Baltim	ore				MXYes 2□		
ifter death with the Mai r items 23a or 28a-f e inter must be notified Funeral Director	10e. Street and Number 411 Esdale Ro	ad		10f. Zip Code 2122	9	10g. Citizen of Whet Country? USA				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Vever Married 2 3	If Yes Give	s? X ^{No}	13. Was Decedent of If Yes, specify Cut		(Specify Yes or No- erto Rican, atc.)	Black	- Amarican Indian, , Whita, atc. Black		
	15. Dece (Specify only his Elementary/Secondery (0-1 10th Grade	dent's Education ghest grade completed) 2) College (1-4c))r 5+)	16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) Health Aid			Home in The Pines Nursing Home			
	17. Fathar's Nama (First, Mide	dla, Last)	inea.	rui Aig		ame (First, Middle, I	Maiden Sumame)		
	Howard Huey	anabia (Tima Brian)	1 405	A 4- Min on Andreas on Affrica	Edith 1		City on Forms	Note Tin Code)		
	19a. Informant's Name/Ralati Sallie Colber	t (Type, Print) Si	ster 196. 450	Meiling Address (Stree 03 Wakefie:				Md. 21216		
	20a. Method of Disposition 15 Burial 2 Cremati 4 Donation 5 Othe	on 3 Removal from Sta	cemetery	Disposition (Name of crematory or other plays) No Cemeters				city or Town, State		
permit. Depertm Importas any Inju	Woodlawn Cemetery March 12 Baltz 21. Signature of Funeral Service Locates 22. Nama and Address of Facility Nutter Funeral Facility Nutter Funeral Facility Service Property Service Funeral Facility Nutter Funeral Facility									
Physician /Medical Examiner	23a. Part1. Entar tha disease shock, or heert feilure. Immediate Cause (Finel disease or condition resulting in death)		omators Due to (or es e co	Panine	7 S-3pe	J)		Onset and Death		
tificate be executed by physicien end es the bunal-transit										
- 00										
ettendin for use	Part II. Other significant cond	delone contributing to doub	but not condition in t	the underhing govern	han in Bart I	23h Did to	heara use cont	ributa to the cause of dea		
as that the deeth cerigned by the ettendir be detached for use by Physician/A	1.) Dieboks	Mellits				1 🗆 Y		3 Probably 4 Unkn		
aw requir	2) Hypertens	we atterase	levote (renery w	tey	24a. Was a perfor	n autopsy med?	24b. Were autopsy finding available prior to completion of cause of death?		
cete had com	dis					1 🗆 Y	es 200No	1 ☐ Yes 2D No		
Physician: The rhis certificate ral director, pag. To Be Co.	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 ER/Outp	patient 3 DOA	thos:	eath (Check only or Home 5 Reside		(Specify)		
After fune	27. Manner of Deeth 1 Natural 5 □ Per	28e. Date of I	njury 28b. Tir	me of 28c. Injury		28d. Describe ho				
To the Hospital or Attending P within 24 hours ettar death. To the Funeral Director. Aftert completely filled in by the funer Medical Certification:	3 ☐ Sulcide 6 ☐ Co	uld not be ermined 28e. Placa of building,	Injury - At home, farretc. (Specify)	n, street, factory, office		28f. Location (S City or Town		r or Aural Route Number,		
Hospi 24 hour Funer etaly fill	29a. Certifier 1 Certi (Check only 2 Medi	fying Physician: To the be- cal Examiner: On the basis and manner	of examination and/	death occurred at the t for Investigation, in my	ime, date end pla opinion, deeth oc	ce, end due to the c curred et the time, d	ause(s) end mar ate and pleca, a	ner as stated. nd due to the cause(s)		
of the omple	29b. Signature and title of per				se number	2	9d. Date signad	(Month, Day, Year)		
j= ≤ j= Ω	///			13	9587		3/8/	199		
- \$ - 0								/ /		
- 5 - 0	30. Nama and eddress of pers	son who completed cause o	f death (Item 23a) (T							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent'e Name (First, Middle, Last) 3. Time of Death Month Mary Pauline House 10:55 AM February 27, 1999 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Anne Arundel Annapolis Sparr Creek Nursing Home If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Min. March 19, 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country). 1□ M 2□ F 87 1911 Maryland 055-03-3676 Yrs Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21403 35 Milkshake Lane U.S.A. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Detes: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) unknown Sales

18. Mother's Name (First, Middle, Meiden Surneme)

Margaret L. McEntee

8517 Black Star Circle, Columbia, Maryland 21045

20c. Location - City or Town, Stete

Dr. Janiko mo 21012

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

with the Meryland r than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at 2 should be filed within 72 hours efter death on end Mental Hygiene.
Is marked other than "netural", or itams 23. altimore, Maryland 21215-0020 permit, Pages 1 and 2 sh Depertment of Health end Important: if item 27 is m any injury or other traum pnce.

Physician

/Medical

Examiner

10a. Stete

17. Fether's Neme (First, Middle, Last)

20e. Method of Disposition

Joseph T. Robinson

Tracy Rudomanski/granddaughter

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete

19a. Informent's Name/Reletionship (Type, Print)

4 Donetion 5 Other (Specify)

Directo

Funerai

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Completed

Funeral

Director

Physician /Medical Examiner

the ettending physician and hed for use es the burial-transit certificate be executed

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After this

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I Director: After by in by the funer

Hospital 24 hours

To the I within 2 To the F

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Box 68760.

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Division of Vital Records,

Examiner Physician/Medical by Completed Be P

21. Signeture of Fundral Service Licansee Ronald S. Wade, 22 Name end Address of Facility State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Pert I. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line. Intervei Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events Due to (or es e conseguença of): Due to (or es e consequence of): resulting in death) Lest 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28a. Date of injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Certification: 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Pieca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)

Registrar

31. Dete filed (Month, Day, Year)

30. Neme end

2

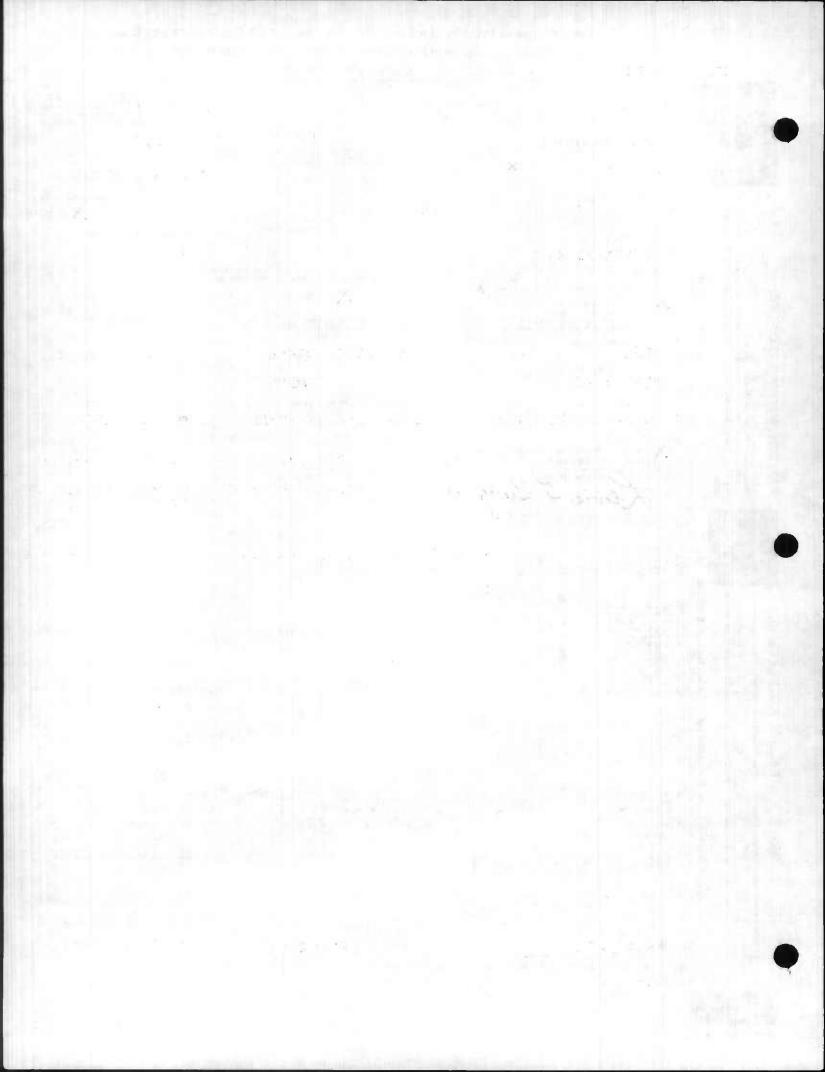
HERMANS 32, Registrer's Signeture

s of person who completed cause of deeth (Item 23e) (Type, Print)

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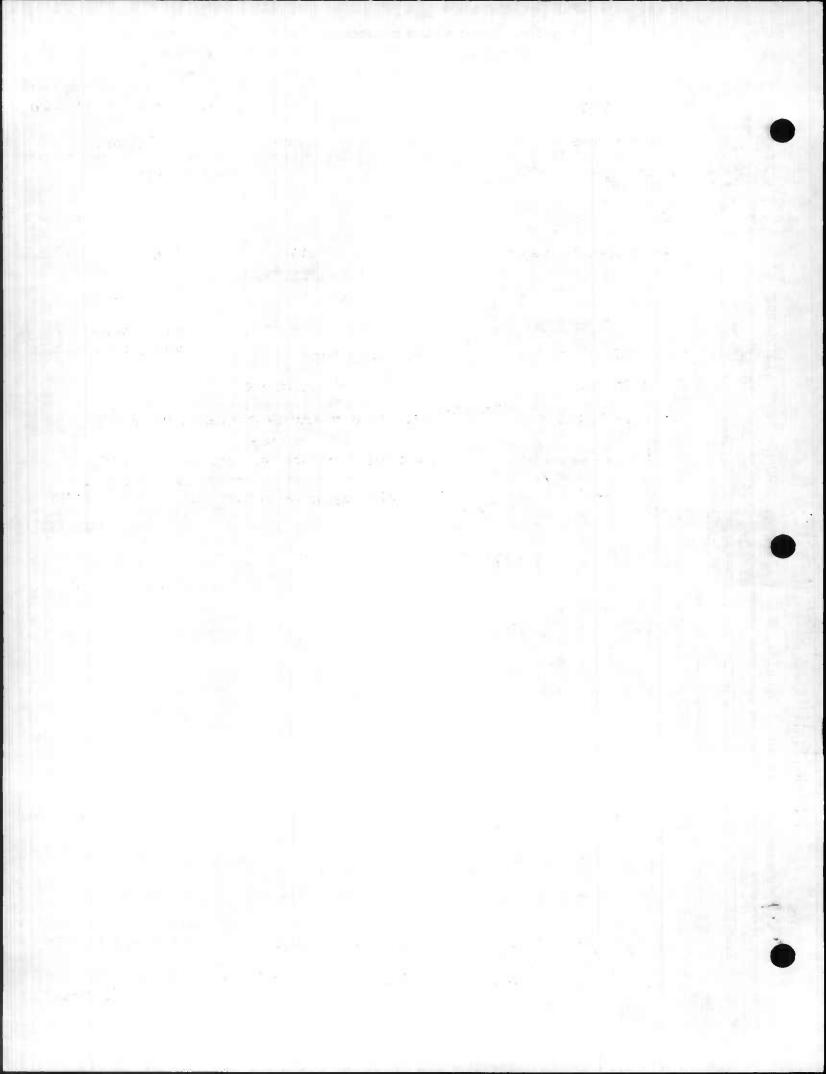
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State of Maryland / Deni	artment of Health and Mental Hygiene
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	_	Decedent's Name (First, Middle, La			icate of		2. Date of Dear		Vaca	3. Time of Death	
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Examiner	40	Facility Nama (If not institution, gi	4b. City, Town, or Loca		ath 4c. County of Deeth						
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uneral rector	1	139 24 4598	Sex 1 □ M 2 KF 7. Age (In yrs. 101		Under 1 Yaar onths Days	Hours Min.	B. Date of Birth (Month, Dey JUN . 22	, 1897	9. Birthpl Count GEOI	ace (Stete or Foreigny) RGIA	
23a or 28a-f show ust be notified at ral Director	10	ha. State 10b. County N / A		ty, Town or Locati					10	od. Inside City Limit	
be notified Director	10	e. Street and Number		1	Of. Zip Code		1	0g. Citizen of V	Vhat Count	ry?	
Sa o		2021 BRYANT AV	JENUE .		2121	7		U.S. OF A.			
or items		. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorcad	12. Wes Decedent Ever in L Armed Forces? 1 ☐ Yas 2 M No if Yes, Give	If Ye	Decedent of I s, specify Cub Yes 22 No	dispanic Origin? (Spec en, Mexican, Puerto R Specify:	ity Yas or No- ican, atc.)		e - America k, White, e	itc.	
		15. Decedent's E	Year or Dates:	16e. Decedent	's Henel Occur	aval Occupation			L L L		
than than		(Specify only highest gr Elementery/Secondery (0-12)	College (1-4or 5+) N / A	(Give kind life. DO	of work done NOT use retire	during most of working			AMTLIES		
5 5 4	17.	. Fether's Name (First, Middle, Las		DOTTE	0110	18. Mother's Name (MILLIA -	
5 e m		ROBERT JONES				UNKNOWN					
Department of Health and Mental Important; If Item 27 Is marked o any injury or other traumatic even once. To Be	19	9a. Informent's Name/Relationship	Route Number	r, City or Town,	Stete, Zip	Code)					
]	TIMOTHY HOLLEY	(SON)	5504	ELDER	ON AVENUE	E BAL	TO., MI	O., MD. 21215		
	200	a. Method of Disposition 1 Burial 2 □ Cramation 3 □ 4 □ Donetion 5 □ Other (Speci	Ramoval from State	Place of Disposition cametery, cremeto NG MEM.	ory or other ple	3/8/99				MD. Co.	
sician edical miner	Im dis re:	3a. Part1. Enter the disease, or con shock, or heart failure. List only namediata Causa (Finel sease or condition soutting in death)	nplications that deused the dear one cause on each line. a. Multiple Due to (th. Do not enter the	na moda of dyi	ARK HEIGH	ITS AV respiretory arr	ENUE		215-639 CO. MD. Approximete Interval Between Onset and Death	
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ettending physician end I for use as the burial-trensit clan/Medical Examine	Cause (Disease or Injury that initiated events rasulting in death) Last Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of):										
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has been signed by the ge 2 should be detached mpleted by Physi		i. Wes case referred to medical				26. Plece of Deeth	perfor	es 2 No	cor of c	illeble prior to npletion of cause deeth?	
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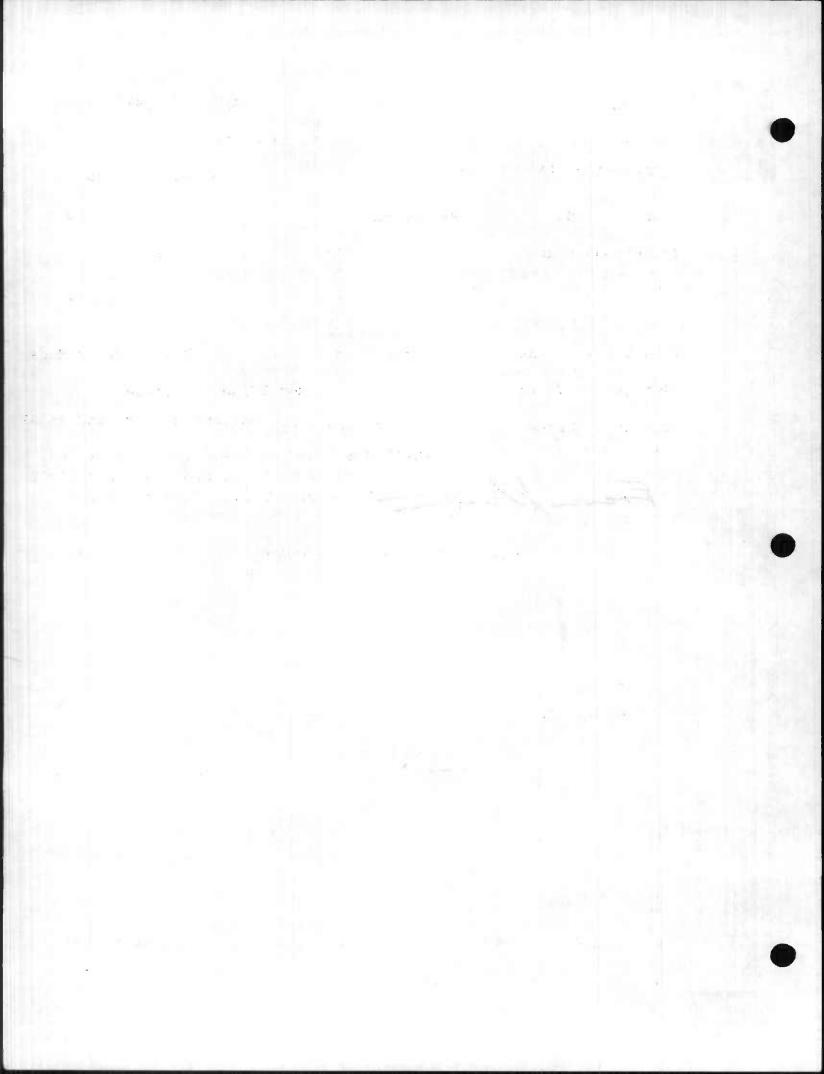
State of Maryland / Department of Health and Mental Hygiene 9 080

									Certific	ate o	f Death		Reg. No.) 0	0001
		Physicia	_	1. Decedent's Nam		Last)						2. Dete of D Month	Day	Year	3. Time of Death
-		/Medic	al L	Allie Ha									10, 19		11:20a.m
		Examine	er '	la Facility Name (umber)				4b. City, Town, or	Location of Dea		inty of Death	
				Gilcrest			7 4 //-	- Inna 6-2-44	eteral If I In	der 1 Yea	TOWSON If Under 24 Hrs.	0 Date of B		timore	
	L	Funeral Director		5. Social Security N 216-09-5 Usual Residence of	594	6. Sex MM 2□ F	7. Age (In yr. 85		Monti			(Month, E	9, 191		iplace (State or Foreign intry)
	we w			10a. State	10b. County		10c. C	City, Town	or Location						10d. Inside City Limits
		Man	Š	Md.	n/a		Ba.	ltimo	ore						1 No 2 No
	Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. To hours after death with the Maryland intropriant: If flem 27 is marked other than "natural", or ferme 23s or 28s-1 show any injury or other traumatic event, the Medical Exercises must be not the and any injury. To Be Completed by Funeral Director	al Dire	3219 Ingleside Avenue					10f.	Zip Code	21215		10g. Citizen USA	of What Cou	intry?	
		ρ		Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Year or Dates:			U,S.		specify Cu	f Hispanic Origin? (Suban, Mexican, Puerlo o <i>Specify:</i>	specify Yes or No Rican, etc.)		Reca - Amer Black, White ecify: Bla	, etc.	
		mpleted	Elementary/Seco	15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					ndustry Le	
	d 2	Hygie Hygie Wher	ပ္	17. Fether's Name		ast)				Lty Officer 18. Mother's Name (First, M.			University Middle Maiden Surmame)		
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	Maryl	d 2 should be ith and Mental I	F	19a. Informent's N Virginia	ame/Relationsh H. Smi	lp (Type, Print) D	aughtei	19b. 891			et end Number or Ru	ural Route Num	ber, City or To	wn, Stete, Z	
	more,	Pages 1 and 3 nent of Health int: if item 27 iny or other tr	1		•	3 □Removal from		Place of cemetery	Disposition (Name of or other p	(ace)Cemeter aptist Ch.	y Date	20c. Locati	on - City or T	Town, State
	E	Departme Importan any Injur		21. Signatere of Fi		-	- 1	7			lress of Facility Nu				
	m	Depariment Important		1	+15	Alex	k	·	2501	Gwyr	ns Falls	PKWY Ba	ltimor	e. Md.	21216
F			,-,	23s. Part1. Enter t	he disease, or o	complications that	carried thy te	ath. Don			ying, such as cardia				Approximate Interval Between
M.SOA		Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final	a	reto				our p				Onset end Death
11		n =	ner				540 (0	C	me	2	oun a	Drim.	my.	site	1 month
10/99	68760,	rificate be executed ng physician end as the buriat-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):											
3		n certifica anding ph	n/Med												
P		death ce	SICIS	Part II. Other signi	ficant condition	s contributing to	death but not re	esulting in	the underlyin	ng cause	given in Pert I.	23b. Di	d tobacco use	contribute	to the cause of death?
711	s, P.O	requires that the been signed by the hould be detache	by Physiciary									10	Yes 221	lo 3□Pr	obably 4 Unknown
Ham lett, Allie	Records,	> 20 00	Completed									24a. We	s en eutopsy formed?	6	Were autopsy findings wailable prior to completion of cause of deeth?
16		The law sate hes t page 2 s	် ပ									10	Yes 22 N	0 1	☐ Yes 2☐ No
3	Vita	ician: The law certificate hes rector, page 2	Be	25. Was case reference examiner?	rred to medical	Hospital:					26. Place of De	ath (Check only	one)		15
7	of Vita	Physician: this certific ral director,	0	1 ☐ Yes 2 ☑ 27. Menner of Deel		11			patient 3	DOA		Home 5 □ Re	sidence 6	Other (Spec	ity) Hospice
	Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	1 Netural 2 Accident 3 Suicide	5 ☐ Pending investigation for a could not be could not b	ation ot be	of Injury nth, Day Year) ea of Injury - At		jury M		☐ Yes 2☐ No				ral Route Number,
	Div	pital or A nurs after oral Directilled in by		4 ☐ Homicide	determin	build	ding, etc. (Spec	city)				City or T	own, State)		
8		e Hos 24 ho e Fun sletely 1	edica	29a. Certifier (Check only one)	2☐ Medical E	xaminer: On the l	e best of my kr basis of examir nner stated.	nowledge, nati <i>on</i> and	death occurr	red at the tion, in my	time, date and place opinion, death occu	urred at the time	a. date and ple	ce, and due	to the cause(s)
	الكنو	withir To th comp	-	29b. Signature and	titler of cectifier	there	Ril	es.	un	29c. Lice	nse number		29d. Date si	gned (Month	, Day, Year)
			3	30. Name and addr	ress of person w	no complete de	se of death (It	m 23a) (1	Type, Print)	N.	Charle	5 7	BAI	to pe	nd
		Stat Registra	~	31. Dete filed (Mon	th, Day, Year)	19 %	Registrar's Sign	neture	la		,			21	205



State of Maryland / Department of Health and Mental Hygiene \(\text{\text{\$\text{\$Q\$}}} \)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death 1999 Year Day **Physician** MARCH Anthony lones 11 4:30a /Medical 4b. City. Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys XXM 20F 215-88-5784 31 Yrs Director 11-30-67 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show inotified at MD 1□Yes 2□No NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiena.
Int: If item 27 is marked other then "natural", or items 23a or inty or other traumatic event, it a Medical Examiner must be a 441 Pitman Place 21202 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: p 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 10th Grade NA Stockman Murray Steak House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) George Geraldine Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, cremetery or other place) Geraldine Banks Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from Slete permit. Page Department of Important: if any injury or Voshell Mem. Gardens 03-16-99 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. Qo not enter the mode of dying, such as cerdiac or respiratory arrest, Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final adult respiratory distress syndrome Weeks disease or condition resulting in deeth) Examiner Due to (or as a consequenca of): Examiner physician and the burial-transit requiras that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): use as t signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No candidal SCPSIS by 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 s 1 X Yes 2 □ No 1 ☐ Yes 2K No confilicata Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 품 28e. Dete of Injury (Month, Day Year) inneral 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Natural Amending 5 Pending I or Attending after death. Director: Att 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide 24 hours Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) and manner stated. To the Within 2 To the Journal 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dev. Year) KSluggeron, MD March 11 1999 Res 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keliegh Culpepper Johns Hopkins Hospital 31. Date filed (Month, Dey, Year) MAR 1 5 1999 32. Registrar's Signature Registrar

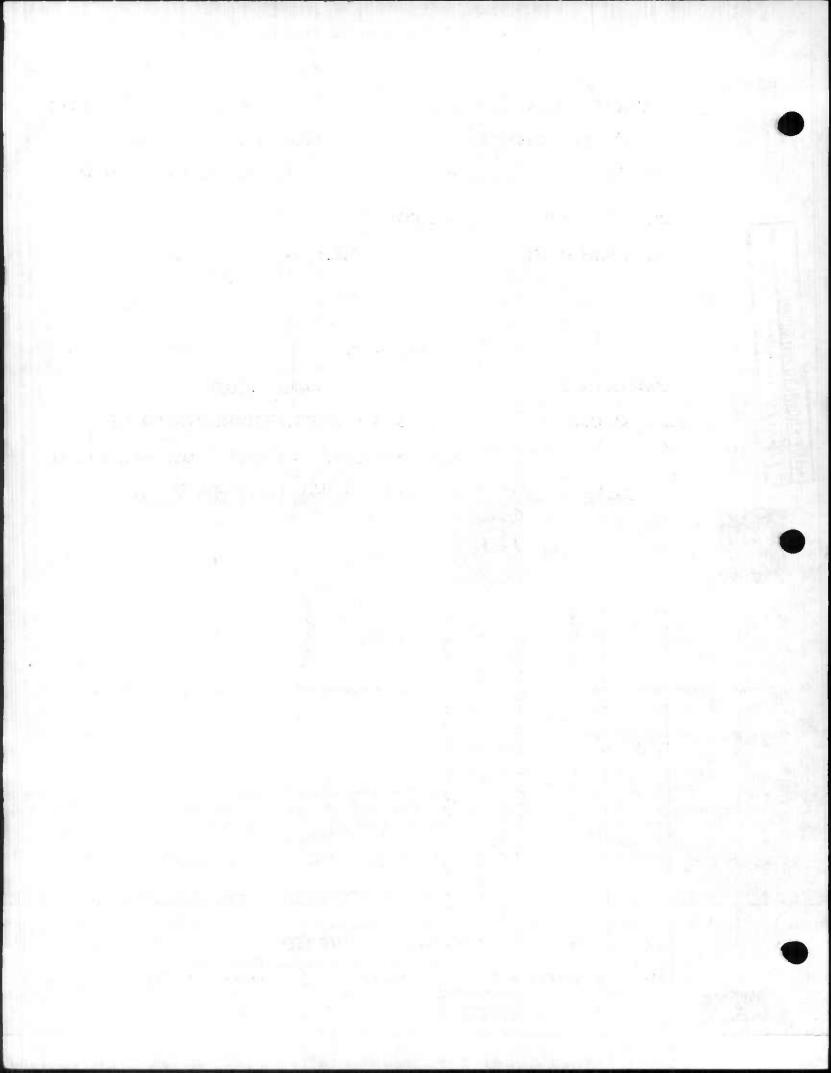


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Dacadant's Name (First, Middla, Last) 2. Date of Daath **Physician** Month FRANCES MARCH 0705 /Medical 4a. Fecility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHURCH HOME HOSPITAL BALTIMORE Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) OCT. 4,1913 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 9. Birthpiace (Stata or Foreign MARY LAND 215-05-5492 85 Yrs. Director Usual Rasidance of Decadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits must be notified Director 1XXVas 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 715 S. DEAN STREET 21224 U.S.A. Funeral 12. Was Dacadant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yeer or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxicen, Puerto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1X Navar Marriad 2 Married b 1 Yas 2XXNo Specify: by 3 Widowad 4 Divorced WHITE Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 SALESPERSON RETAIL 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Meidan Sumeme) Be LAWRENCE KALB 0 ANNA MUELLER 19a. Informant's Name/Relationship (Type, Print) WCCS 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 715 S. DEAN STREET, BALTIMORE, MARYLAND 21224 sportant: If Itam 27 LILLIAN KALB/SISTER 20a. Method of Disposition

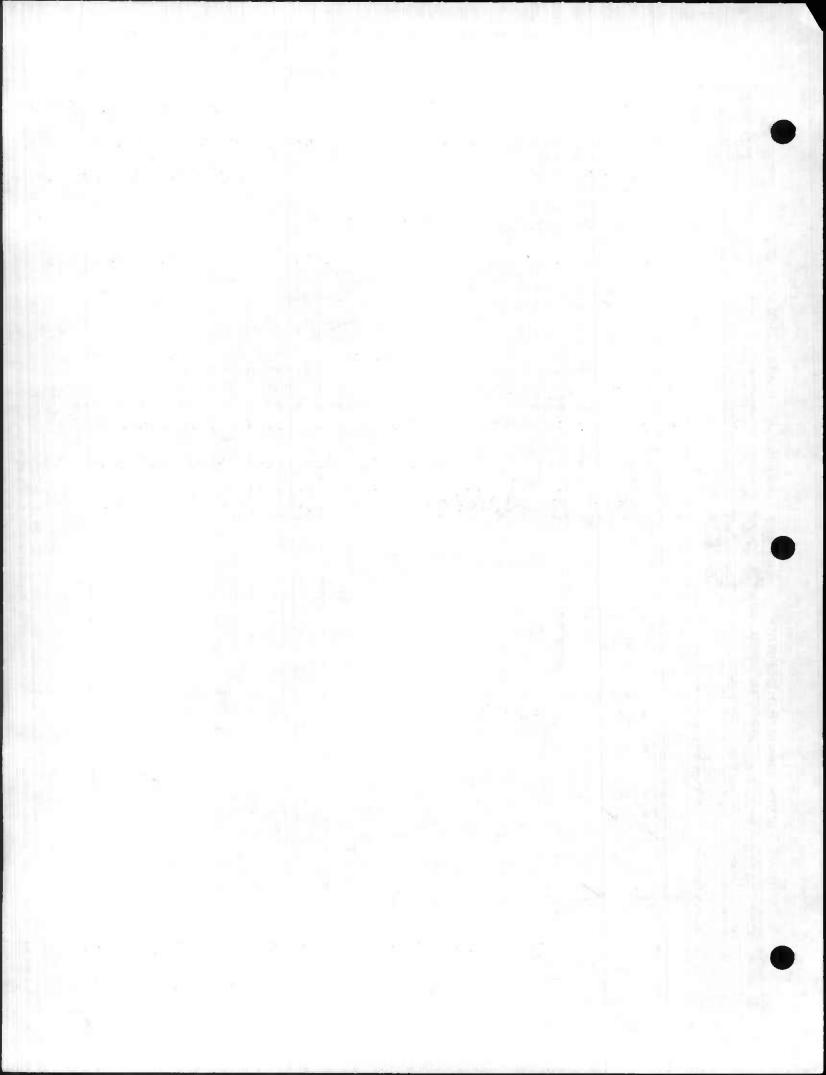
→ Cramation 3 □ Removal from Stata 20b. Plece of Disposition (Name of cematary, crematory or other plece) 20c. Location - City or Town, Stata tmo Timo 4 Donation 5 Othar (Specify) PARKWOOD CEMETERY 3/12/99 BALTIMORE, MARYLAND 21. Signetura of Funaral Sarvice Licansae 22. Nama and Addrass of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 21224 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximeta Intarval Between Onsat and Death **Physiclan** Immediata Cause (Finei diseasa or condition resulting In daath) /Medical PNEUMONIA Examiner Dua to (or as e consequance ot): Physician/Medical Examiner CHRONIE ASPIRATION or Attending Physician: The law requires that the death certificate be executed use as the bunal-trar Sequentially list conditions, if any, leeding to immadieta ceuse. Enter Underlying Causa (Disease or Injury that injured events.) Box 68760. physician that initiated avants resulting in deeth) Last Dua to (or as a consequence of): P.0. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Cardiovasoular Disease Atherox duratic 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, þ Completed 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to complation of ceuse of death? 1 Yas 2 No 1 Yas 20 No of Vital 25. Was cesa ratarred to medical axaminer? Be 28. Placa of Death (Check only ona) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yas 2 No 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Dascribe how injury occurred After 5 Panding Investigation s effer des. 1 Tes 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, tarm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicida To the Hospital of within 24 hours of To the Funeral Discompletely filled in 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, data and piece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner stated. Medical 29a. Certifiar (Check only one) 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) D40356 and-Specialist Mavaustry MARCH 30 Nama and address of person who completed causa of death (Item 23a) (Type, Print)

NENEUSA NAVARRO, MD: 100 N · Broadway, Battimore, Haryland 2/23/ 32. Registrer's Signatura 31. Data filed (Month, Day, Year) State MAR 1 5 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 3:40/40 MILTON LUCKERT MARCEL 14, /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Northwest Hospital Center Baltimore Randallstown If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**∑**M 2□ F Months Deys 79 Yrs. 212-07-9588 July 17,1919 Director Maryland Usual Residence of Decedent the Maryland r 28a-f ahow 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Sykesville Maryland Carroll 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number with 7 is marked other than "natural", or items 23a or treumatic event, the Medical Examines must be a 6013 Crossway Court 21784 United States 2 should be filed within 72 hours efter death on and Mentel Hyglene.
Is marked other than "natural", or items 23: Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Yes 2☐No tf Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes XIXNo Specify: White Specify: þ 3 Widowed XDDivorcad Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4pr 5+) 9 Welder Shipbuilding 17. Fether's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 is marked other any liquy or other traumatic event pice. Milton Conrad Luckert Wagner Rose 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 6013 Crossway Ct. Sykesville, Md. 21784 Barbara Aymold / Niece 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurlal 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery3/18/99 Baltimore, Md. 21. Signature of Funeral Serving Licenses 22. Name end Address of Fecility Ambrose Funeral Home, Inc. 21227 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart fellure. List only one cause on each line. Md. Approximete Interval Between Onset and Death **Physician** There mo me Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Examiner physician and s the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lesf Due to (or es a consequence of): Box 68760 Physician/Medicai Due to (or as e consequence of): signed by the a 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown emen Division of Vital Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? peen has 1 ☐ Yes 2 ☐ No 1 Yes 2 DINO certificate : After this certifical or Attending Physician: offer death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 16 2 ER/Outpatient 3 DOA Certification: To 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours e Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune completely fi (Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year) 29b. Signature and title of cept 29c. License number MI son who campleted crose of deeth (Item 23a) (Type, Print) 30. Name and address of mo - NW He IMPERIAL 32. Registrar's Signeture 31. Date filed (Month, Day, Yeer) State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Malinda Little 9:05AM February 27, 1999 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner The Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□M 2□F 212-56-3799 48 Yrs. Director 08-24-50 MD Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Hessith and Mental Hygiene.
The permit if then 37 is marked other than "netural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercites must be notified as Yes 2□No MD NA Baltimore Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 407 E. North Avenue 21202 Black Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race · American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: py 3 Widowed 4 Divorced Black Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Laborer Unemployed 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Thomas Southers Addie Baker 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21213 Southers 3712 Bonview Avenue baltimore, Maryland 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Suriel 2 ☐ Cremetion 3 ☐ Removel from State Voshell Mem. Gardens 03-03-99 4 □ Donetion 5 □ Other (Specify) Dundalk, MD 21. Signeture of Funerel Servica Licansee 22. Name and Address of Fecility Baltimore, Maryland 21202 -WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) . Endocaditis 3 weeks Examiner Examiner Bacteremia 3 weeks physician and the burial-transit that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): 5 years Chronic Narcotism Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Infection Retrovirus 2 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed certificate has t irector, page 2 s 1 Yes 2 No 2 10 No Attending Physician: 25. Wes case referred to medicel examiner? 26. Plece of Deeth (Check only one) Be

1 Yes 2 No 27. Manner of Deeth

12 Neturel 5 Pending Investigation 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

Hospitel: 1 M Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dev Year)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

1 □ Yes 2 □ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end due to the ceuse(s) end menner steted.

| Madical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier

29c. License number RES-000 29d. Dete signed (Month, Dey, Year) February 27, 1999

CBoyd MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Cynthia Boud

110 Tower

Johns Hopkins Hospital

State Registrar

0

Certification:

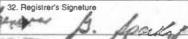
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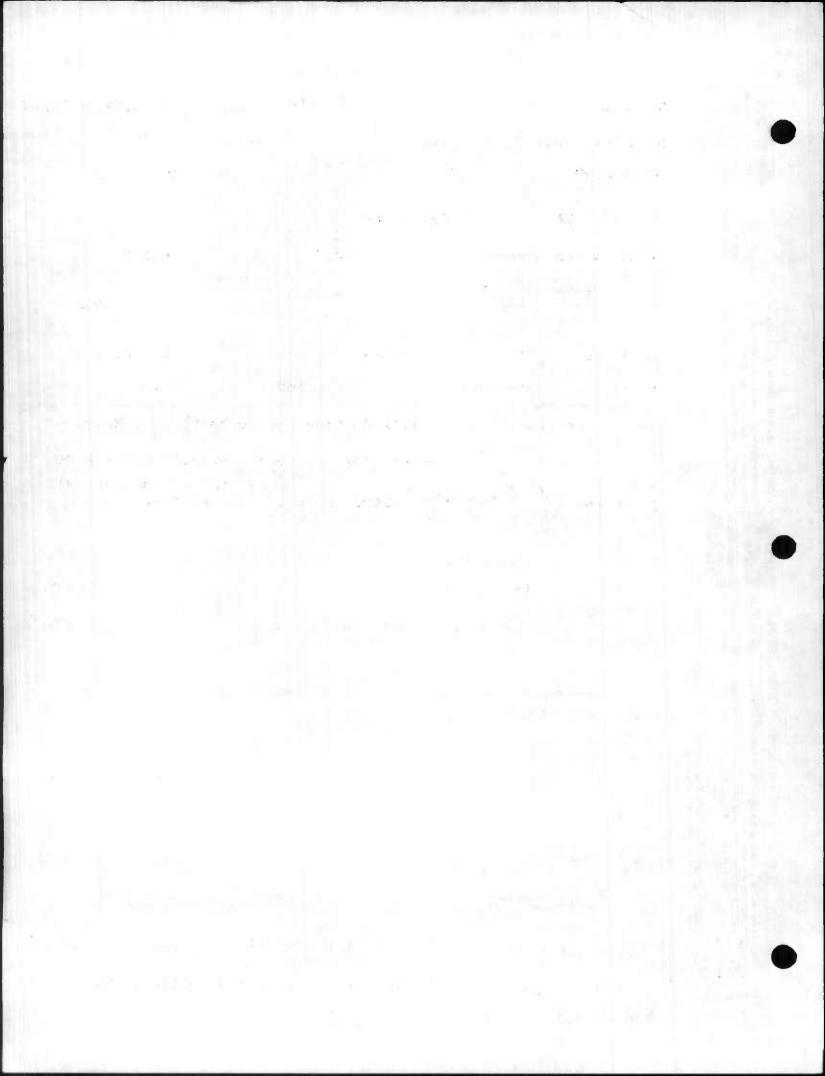
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Mospital or Attending 24 hours after death. Funeral Director: Aft

To the Hospital on Within 24 hours aft To the Funeral Di completely fillad in

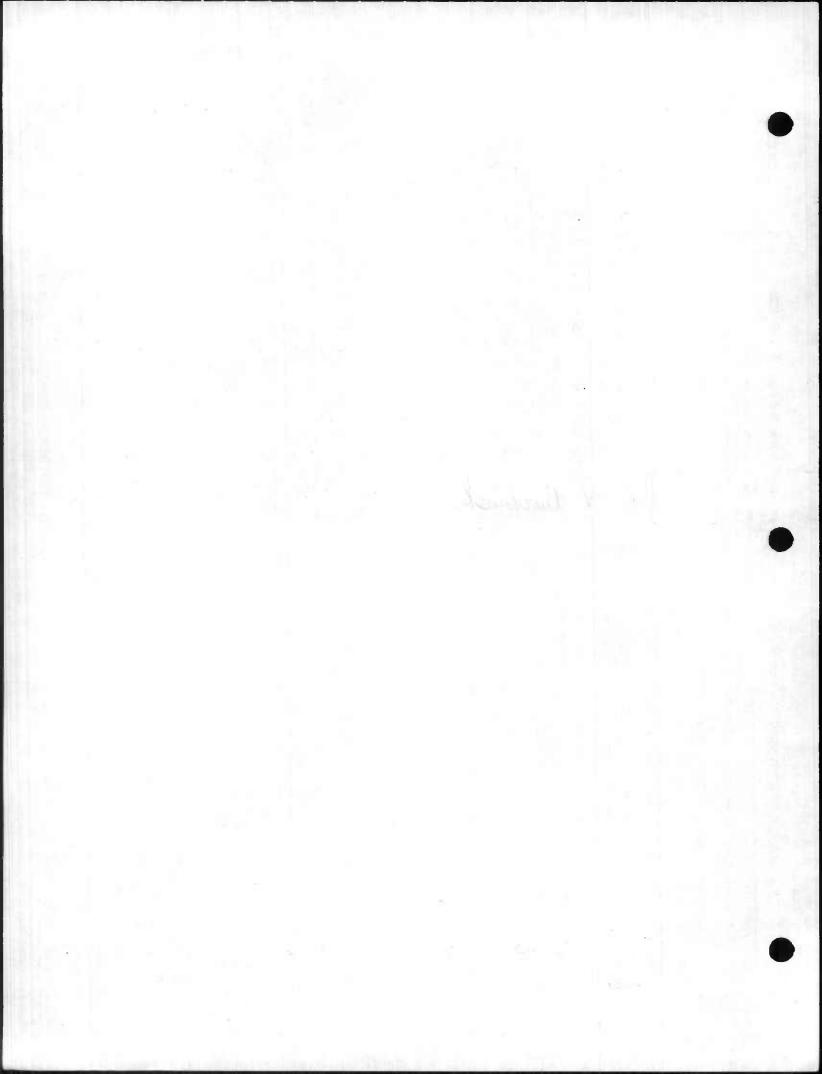
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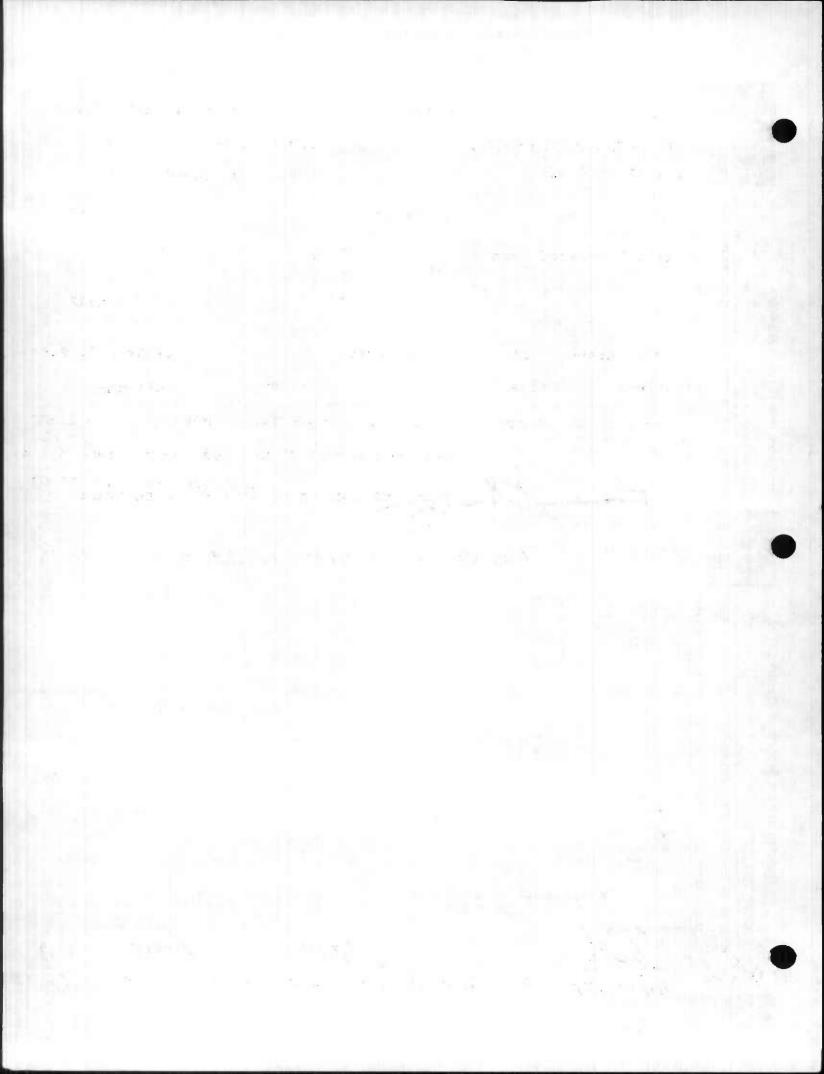
State of Maryland / Department of Health and Mental Hygiene 9 08072

			C	ertificate d	of Death			Reg. No.	0 (011	-009
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Examiner	4a Facility Name (If not institution, gr				4b. City, Town, or Location of Death Raspeburg Raltimo						
	615 Meadow Rd 5. Social Security Number 6.	Sex 7. Age (In yrs	R If Under		8. Date of Birth (Month, De)			more	or Earnian		
Funeral Director	218 30 6970 1□ M 2⊠ F 62 Yrs. Months Days Hours Min.							1936	Mary	lace (Stete of try) land	n r oraigir
/land	10a. State 10b. County	10c. C	ity, Town or	Location					1	0d. Inside Ci	ity Limits
Man de fait	Maryland Balt	imore	R	aspebur	g					1 🗆 Yes	2⊠No
sth with the Marylar 23a or 28a-f ahow ust be notited at ral Director	10e. Street and Number 615 Meadow Rd	•		10f. Zip Cod 2 1	206		10g. Citizen of What Co USA			try?	
Herne Herne	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	2X No 1 □ Yes 2È		of Hispanic Origin? (Specify Yes or I Cuban, Mexican, Puerto Rican, etc.) No Specify:			No- 14. Race - American Indian, Black, White, etc. Specify: White			
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id 212 flied with Hygiena. other than ant, the		t)			18. Mother's Neme (First, Middle, Meiden Surneme)						
arylanc should be fi ad Mental H marked out matic ever	(Unknown)				Dorothy Bentz						
Mar nd 2 sh ith and 27 is m	19a. Informent's Name/Relationship Eugene Leeb (Husb				oss (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) OW Rd. Baltimore, Md. 21206						
P P P P P P P P P P P P P P P P P P P	20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 [Placa of Dis cemetery, c	sposition (Neme of rematory or other	plece)		Date	20c. Location	City or To	wn, State	
altimor ni. Pages arment of ortant: If he injury or o	4 Donation 5 Other (Special	fy) M	orela	and Mem	orial	Pk.	3/16/19	99 E	Balti	imore	, Md
Baltimo permit. Page Department important: if any injury or page.	21. Signature of Funeral Service Lice	Russe Burn B		22. Name and Ad Bruzdzi 1407 Ol	dress of Facili nski d Eas	Fune tern	ral Ho	ome P. ue Ess	A. ex,	Md. 2	21221
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/Medical Examiner	immediate Cause (Final disease or condition resulting in death)		:	man	ths						
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orc requir hould hould				A			24a. Was perfo	an autopsy med?	BV:	ere autopsy f allable prior t mpletion of c	10
The taw ate has by page 2 s							101	es 2 No		death?	No
VITAL Re- sician: The lav certificate has rector, page 2 Be Comp	25. Wes case referred to medical				26. Place	e of Death	1 Yes 2 No 1 Yes 2 No				
Of VITa Physician: this certific rai director,	examiner? 1 Tes 2 No	Hospital:	ER/Outpat	ient 3 DOA	Other			lence 6 Ott	ner (Specifi	y)	
ng Ph fer th ineral	27. Manner of Death 1 ☑Netural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time Injury	of 28c. i	njury at Work?	2	28d. Describe h	ow injury occur	red		
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Diversity of the birds of the b	4 Homicide	building, etc. (Speci					City or Ton				
Hospi 14 hou Funer taly fill	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my knowning. The miner: On the basis of examinating and manner stated.	owledge, de etion and/or	eth occurred et the investigetion, in m	time, date en y opinion, dea	nd place, a ath occurre	and due to the dead et the time, d	cause(s) and m date end plece,	anner as si and due to	ated. the ceuse(s	5)
To the virthin To the compie	29b. Signature and title of certifier			29c. Lic	ense number			29d. Date signe	d (Month,	Dey, Year)	
	Escent	f Just M			187-Kei mese 13, 1 Utimore, MD 21237			1995			
	30. Name and address of parson who	completed cause of death (Ite	m 23a) (Typ	e, Print)				0.77			
		KIIN Squere	Dri	ve Ba	1+imor	e, N	ID 21	237			
State Registrar	31. Date filed (Month, Dey, Year)	32. Registraris Sign	ature	D. A.	could						



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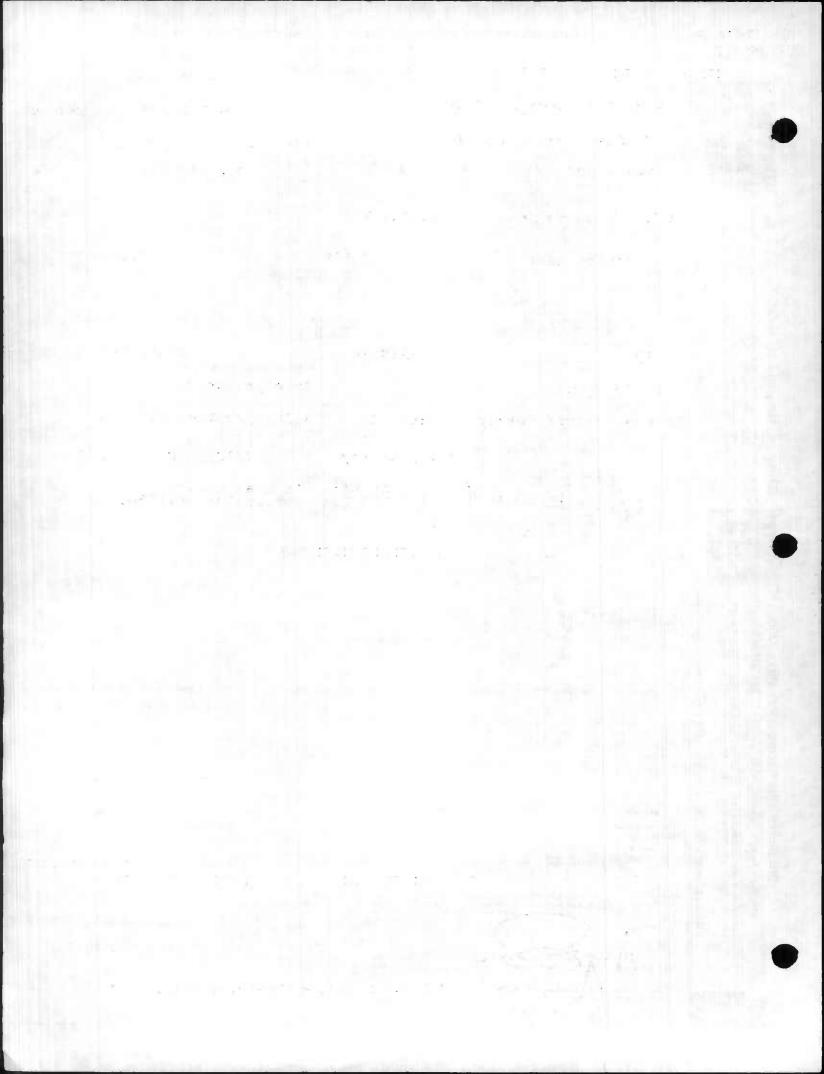
ROBERT MICKEY **ARCH** 11 1999 **O6:08 **O6:08 **ARCH** 11 1999 **O6:08 **O6:08 **ARCH** 11 1999 **O6:08 **O6:0	ician	Decedent's Neme (First, Middle, Las	at)		Certificate of	Dealli	2. Dete of Dec	Reg. No.	3. Time of Dec
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19th Lifton mark Name/Relationship (Type, Print) 19th Melling Address (Sireer and Number or Fural Route Number, City or Town, Steles, Zp Code)		17. Fether's Neme (First, Middle, Last)				18. Mother's Nerr	e (First, Middle,	Maiden Sumeme)	
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Immediate Cause (Final disease or conditions) Bout to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause given in Pert I. Due to (or es e consequence of): Due to (or es e consequence of): Cause (Disease or injury that indicated events resulting in death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probabity 4 Uritary 24e. Wes en eutopsy performed? 25. Wes case reterred to medical examined? 25. Wes case reterred to medical examined 4 Inpatient 2 EP/Outpatient 3 DoA Other: 4 Nursing Home 5 Pending Investigation 5 Suicide 4 Homicide 28e. Diate of Injury - Al home, farm, street, factory, office 28t. Location (Street and Number or Rurel Route Number and menner stated. 29b. Signalyre and hits of gentitier 29b. Diate of injury opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.	DUCE	21. Signature of Funeral Service Licens	See / 4			Ва	ltimor 101 E.	e, Maryl North	land 2120 Avenue
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State of Maryland / Department of Health and Mental Hygiene 9 9 0 8 0 7 1

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(Specify Yes or Not Year's Original Children	Firmaine Dewayne Moore # Fallity Name (first instation, pre street and number) ANNE ARUNDEL GENERAL HOSPITAL **Social Security Number** 216 – 88 – 740 8 **OM** 21 F** 25 F** Months Builder 1 Year** Year** Builder 1 Year** Year** Builder 1 Year** Builder 1 Year** Year** Builder 1 Year** Year**	Filmaine Devayne Moore 4 c City Town of Location of Devil 4 c County of Devil ANNE ARINDEL GENERAL HOSPITAL 5 social Society National Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Social Social Society Social Social Social Social Social Social Society Social Social Social Society Social Social Society Social Social Society So



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Yaar Elizabeth Margaret Mohr 30 AM narch 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Ba /timore Canter Rose dale tranklin 1 ospital uare 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Data of Birth (Month, Day, Year June 26, 9. Birthplace (State or Foraign Country) Maryland 5. Social Security Number Hours Year) 1□M 2√F 213-10-3135 1919 Yrs Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1026 Chesaco Avenue 21237 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Navar Married 2 Married 1 Yes 2 No Specify: Specify: White 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Government 6 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Daniel James Sullivan Elizabeth Margaret Eckstein 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Saul/daughter 1026 Chesaco Avenue, Baltimore, Maryland 21237 20b. Place of Disposition (Name of 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Othar (Specify) 21. Signature Rohald S. Wade State Anatomy Board, 655 W. Baltimore Street Director luce Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in death) 7400 Due to (or as a consequence of): Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Diseasa or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Discare 24b. Wera autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of

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Physician

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ortant: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other treumstic event, the Medical Examiner must be notified at

"natural"

permit. Peges 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other trainment.

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Baltimore, Maryland 21215-0020

25. Was casa rafarred to medical 1 Yas 2 No 27. Manner of Death 1- Natural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida

29a. Certifier (Check only

🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated.

franklin

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Savitha 9000 hivananda

21237 Baltimore Maryland

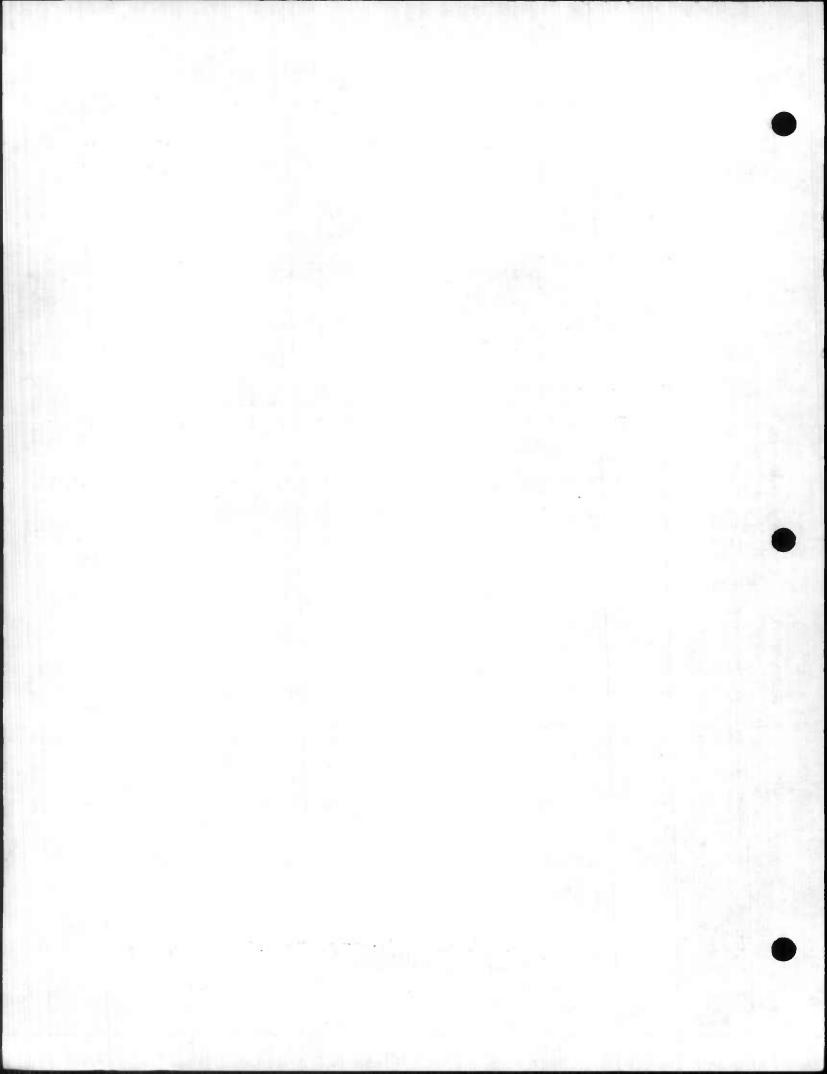
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within 2 \$

Medical

31. Data filed (Month, Day, Year) MAR 1 2 1999 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dafa of Death 3. Time of Deeth **Physician** /Medical 4c. County of De 4e Fecility Nema (If not institution, give street end number) Examiner Birthplace (State or Foreign Country) **Funeral** Days LEIM 20 F Director Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. inside City Limits Maryland Baltimore City 1 → Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Counfry? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Haalth and Mental Hygiena.
Important: if item 27 is marked other than "natural", or heme 23a or 2 any injury or other traumatic svent, the Medical Examiner must be nonce. 124 W. Franklin Street 21201 U.S.A. Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: Wes Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien. Black, White, atc. 11 Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Produce 6 0 Salesman 18. Mothar's Nama (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Frank Martinek Jeanette Hartman 2 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) 2724 Glengyle Drive, Vienna, Virginia 22181 Josephine Gullace/niece 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State 4☑ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licensea Ronald S. 22. Nama and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street Director Wade. Baltimore, Maryland 21201
23a. Pat1. Entar tha disaase or complications thet caused the daeth. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Batween Onset end Deeth **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical umonar hemorshag Due to (or as a consequence of): Examiner arc 10 cardial Sequantially list conditions, if eny, leading to immediata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting In death) Lest One to (or as a consequence of): Physician/Medical Dua fo (or as e consequance of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara eutopsy findings availabla prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 2 12 No 1 Tyes 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Pleca of Deeth (Check only one) Hospital: 1 Yas 2 No 1 Dinpatient Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Panding invastigation 1 Yes 2 No 2 ☐ Accident 3 Suicide

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the Maryland

Baltimore, Maryland 21215-0020

notified at

Examiner

6 Could not be datarmined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homloida 29a. Cartifiar 1 Certifying Physicien: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signatura	and titla of	certifiar	(1)
10	Kerlo	h	(Ven

29d. Data signed (Month, Dey, Year)

30. Name and eddress of person who completed caysa of death (Itam 23a) (Type, Print)

Kala Danushkodi, M.D. 40 / Kala

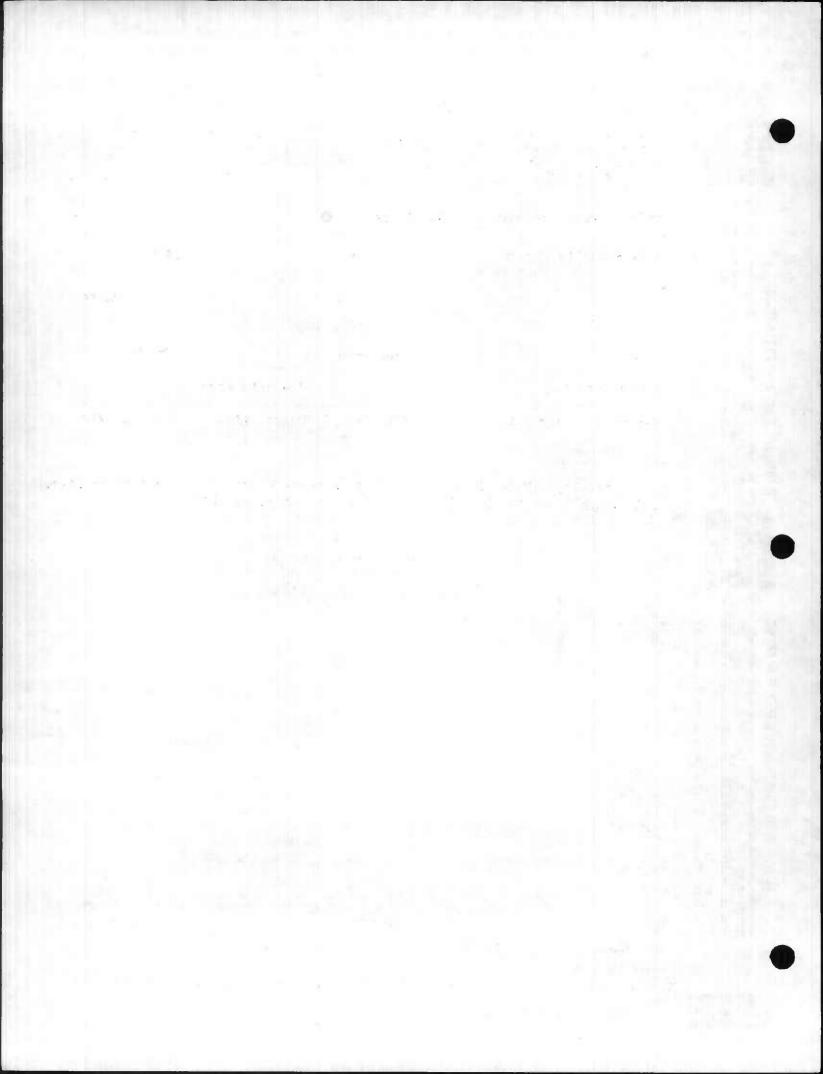
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To the within 2



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Dorothy F. Marshall February 14, 1999 3:58 AM 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Wicomico Salisbury Senior Ouarters at Chesapeake Landing 8. Date of Birth (Month, Day, Year) March 4, 1916 If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 1 □ M 2 ₽ F 82 Maryland 220-28-0681 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland | Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 U.S.A. 1110 Healthway Drive 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Married 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Retail 0 Sales Clerk 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Letha Violet Calver Virgel Clyde Marriner 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 Healthway Drive, Salisbury, Maryland 21801 James T. Marshall/husband 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete Date cemetery, cremetory or other place) 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 ☐ Other (Specify) 21. Signetyre of F Peneral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Baltimore, Maryland 21201 23a. Perit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel diseese or condition resulting in deeth) a Dement Due to (or es a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20XNo 3 Probably 4 Unknown Emphysem, Hypothyrodis, 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident NA

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

3/8/97

29d. Date signed (Month, Day, Year)

the burial-transit The law requires that the death certificate be executed P.O. Box 68760. Records, 90 certificate Division of Vital or Attending Physician: funeral director, After this

Examiner Physician/Medical Be Completed by Certification: To

Medicai

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show oficel Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or then any Injury or other traumatic event, the Medical Exerci-

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

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after death. filled in by 24 hours a complataly

Hospital

To the I

045775 30. Neme and a dress of person who completed cause of deeth (Item 23a) (Type, Print) d (Month, Day, Year) 32 Registrer's Signature 31. Dete filed (Month, Dey, Year) State MAR 1 2 1999 Registrar

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

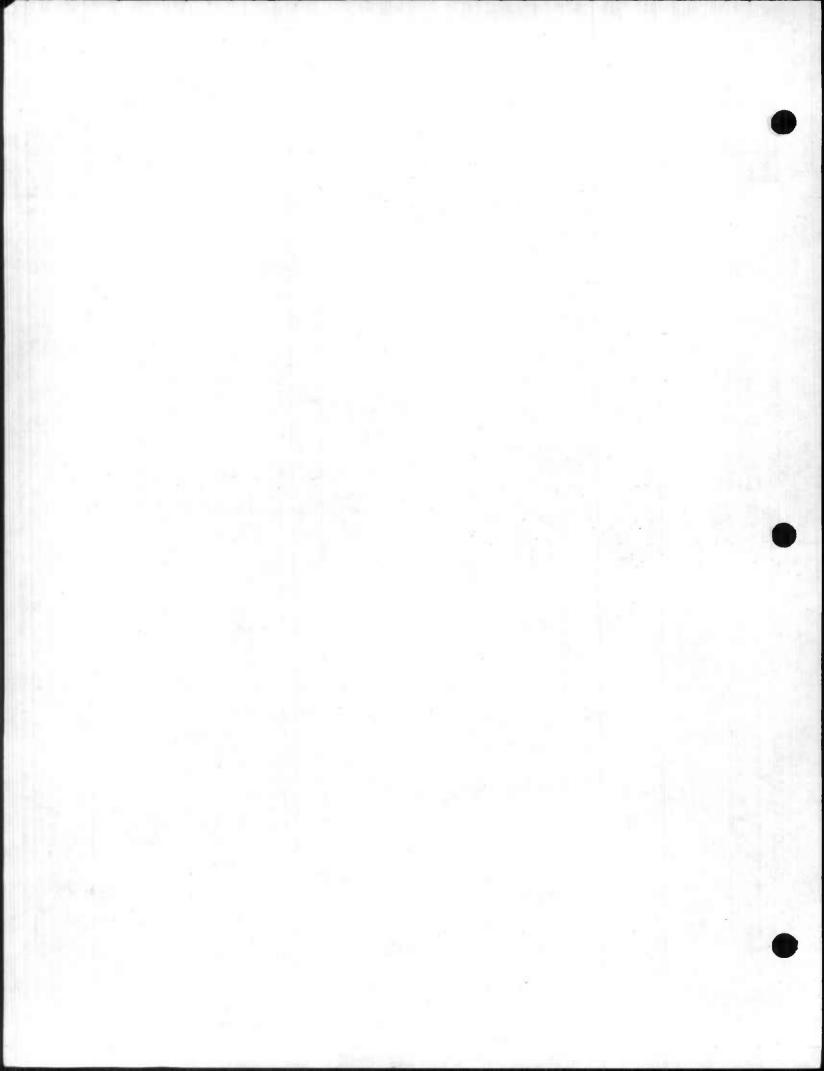
29b. Signeture, and title of certifier

DHMH 16 Rev 6/95

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



99-1392-510

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiana. Introportant: If Item 27 is marked other than "natural", or flarm 23s or 28s-f show any injury or other traumatic event, the Medical Examina Transport.

Physician

/Medical

Examiner

attanding physician and for usa as the burial-transit certificata be axecuted

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P.O. Box 68760.

Division of Vital Records,

requires that the death signed by the a

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Examiner

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Certification:

Medical

Baltimore, Maryland 21215-0020

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10b. County

10a. Stata

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	State of Maryland / Department of Health and Mental Hygiene 9) [(

ASON ITE	MS: #23 PART I, 27		0 4-8-99 WR. Cel				eg. No.
Physician /Medical	Decedant's Nama (First, Midd		dward Lee Maso	on III	7 3 5	2. Data of Death Month MARCH	h Day
Examiner	4a Facility Nama (If not Institution JOHNS HOPKINS				4b. City, Town, o	r Location of Death ORE	4c.
Funeral Director	5. Social Sacurity Number 217-94-4912	6. Sex 1 3 M 2 □ F	7. Aga (In yrs. last birthday) 18 Yrs.	ff Under 1 Yaa Months Days			Year)

4c. County of Death N/A Birthplaca (State or Foraign Country)

3. Time of Death

9:43P.M.

Yaar

10,1999

1980 Maryland 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yas 2 ☒ No Edgemere Baltimore

10e. Sfreet and Number 10f. Zip Coda 10g. Citizen of What Country? 21219 2323 Lincoln Avenue United States 14. Raca - American Indian Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedenf of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11, Marital Sfatus 1 Yas 24 No If Yas, Giva Yaar or Datas: № Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced

15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Year Elementery/Secondary (0-12) Student Dependant

17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Dolores J. Kolar Edward Lee Mason, Jr. 19a. Informent's Name/Relationship (Type, Print) Father 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Edgemere, MD 2323 Lincoln Ave. Mr. Edward L. Mason, Jr. 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Removal from Stata

4 ☐ Donation 5 ☐ Othar (Specify) Holly Hill Mem. Gdns. 3/15/99 Middle River, MD 21. Signatura of Funaral Sarvice Lican 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

Part1. Enter the disaasa, of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Lief only one cause on each line.

Approximeta Intarval Batween Onset and Death

immediata Causa (Final disaesa or condition resulting in deeth) CARDIOVASCULAR COMPLICATIONS OF FRIEDREICH'S ATAXIA Dua to (or as a consequence of):

Dua to (or as a consequence of)

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequanca of).

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Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Wes en eutopsy performad?

NE Yas 1 ☐ Yes 2 ☐ No

25. Was casa rafarred to medical axaminar? 26. Place of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No

27. Mannar of Death 28d. Dascribe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Panding invastigation 1 TYas 2 No

2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, deta and place, and dua to the ceusa(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, and dua to the causa(s) and manner stated. 29a. Certifier (Check only

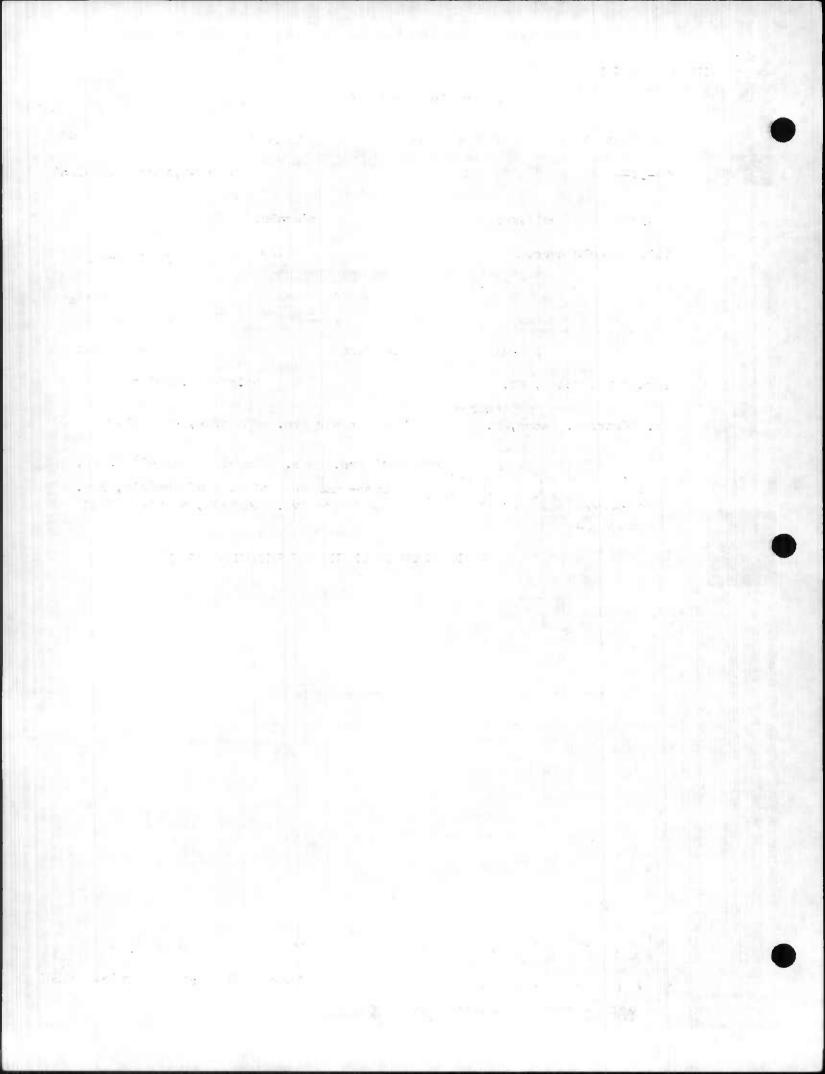
one) 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifian

O.C.M.E. MARCH 11, 1999

30. Nema and address of person who complated causa of daath (Item 23a) (Type, Print) Pysnon 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year) MAR 1 5 1999 Non 32 Ragistrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death March 9, 1999 **Physician** Doris Nichols 4:00 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 4711 Roland Avenue Baltimore 8. Date of Birth (Month, Dey, Year) Oct. 14, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 10 M ZXX Days Hours Months 79 215-42-9595 1919 Maryland Director Usual Rasidence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or frame 23a or 28a-f ahow the Medical Examiner must be notified at X1XX Yas 2 No Director MD N/A Baltimore 10f. Zip Coda 10g. Citizen of What Country? 10e. Street end Number 21210 U.S.A. 4711 Roland Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yas 2212 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after to neat of Health and Mental Hygiene.
Int: If tem 27 Is marked other than "natural", or fiel may or other traumalts event, fre Medical Event, may or other traumalts event, fre Medical Event may or other traumalts event, fre Medical Event may be a second or the second of t 1 Naver Marriad 2 Married 1 ☐ Yes aXXNo Specify: Specify: White altimore, Maryland 21215-0020 à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Balto City School Teacher 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Frederick Kraus Anna Zuloff 19a. tnformant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4711 Roland Avenue, Firmadge King Nichols, III Balto, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a, Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or page. Hilltop Service Corp 3/13 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Burgee-Henss Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximata triterval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner hysician end the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): physician 10 Physician/Medical Due to (or as a consequence of): use as attending Por Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched 1 Yss 2 No 3 Probably 4 Unknown P 24b. Ware autopsy findings available prior to complation of ceusa of death? 24a. Was an autopsy Completed performed' certificate hes t director, pege 2 s 1 ☐ Yes 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director, 25. Wes case referred to medical Be 28. Plece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 27. Manner of Deeth 28b. Time of 5 Pending Investigation 1 Netural To the Hospital or Attandin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Manth, Dey, Year) 29b. Signature and title of certifier

cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

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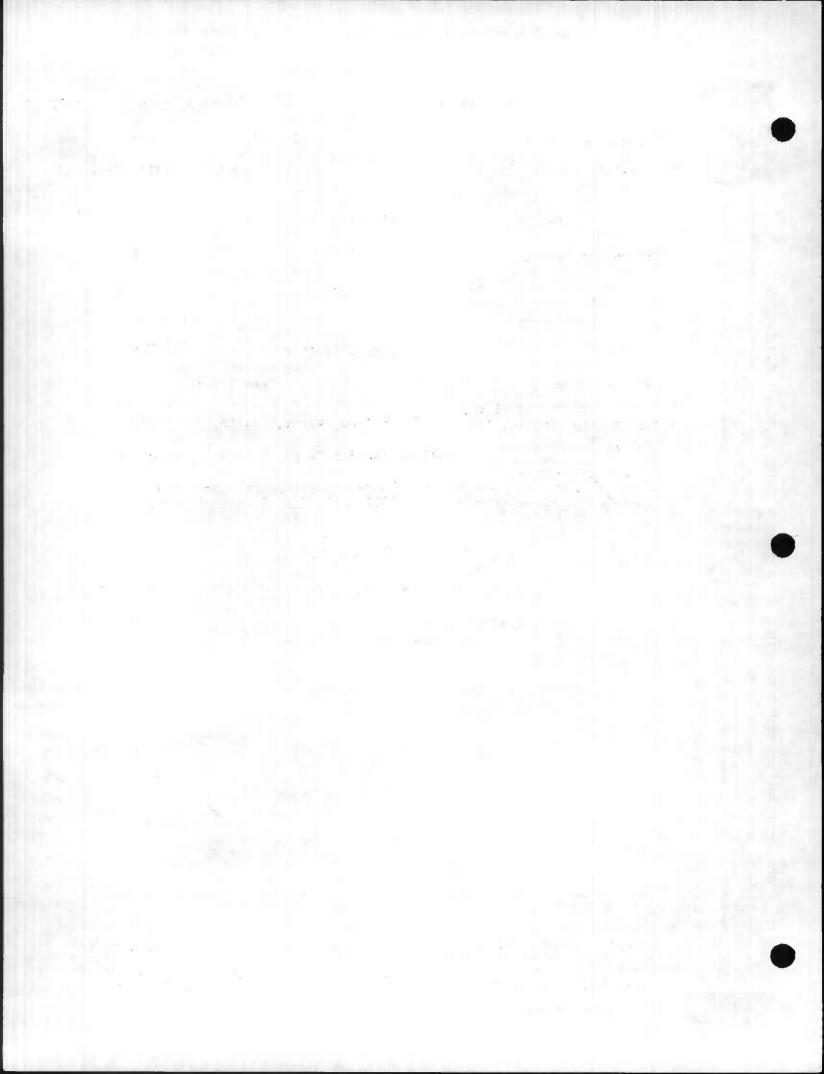
Division of Vital Records, P.O. Box 68760,

State Registrar 30. Name and address of person who

31. Date filed (Month, Dey, Year)

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MAR 1 5 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | #st) 3. Time of Death 2 Date of Death Month **Physician** 0340 A Charles Hillsinger Niles MARCH /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner HARFOR Lorien Riverside Nursing Home Belcamp 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) New York 7. Age (In yrs. lest birthdey) **Funeral** 1 X M 2 □ F Months Deys Hours Min. Yes 212-07-7177 Director 92 Feb. 8, 1907 New Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel; or items 23a or 28a-f show other traumstic event, the Modical Examiner must be notified at 1 Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code Funeral 3701 White Avenue 21206 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White p 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Busineas/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins University permit. Pagas 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "reny injury or other traumetic event, the Head Elementery/Secondary (0-12) College (1-4or 5+) Applied Physics Lab 4 Engineer 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Charles Olin Niles 10 Ollie E. Hillsinger 19a. Informent'a Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Roger C. Niles / Son 1212 Grafton Shop Road Bel Air, MD 21014 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 3/15/99 Baltimore, Maryland Parkwood Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 OUTIMAM 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** derene /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner attanding physician and for usa as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es a consequença of): Physician/Medical Due to (or es e consequence of): conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably Unknown by 24b. Were eutopsy findings available prior to 24e. Wes en autopsy performed? Completed completion of cause of death? 21110 funeral diractor, 25. Was case referred to medical examiner? Be 28. Placa of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury e Work? Aftar 5 Pending daath. 1 ☐ Yes 2 ☐ No investigation 2 Accident or Attend after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Funeral Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the ceuse(s) and manner es stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29e. Certifier edical (Check only one) To the I within 2 To the F

Registrar

31. Date filed (Month, Dey, Year)

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29b. Signature a

5 1999 MAR 1

0 32. Registrar's Signature

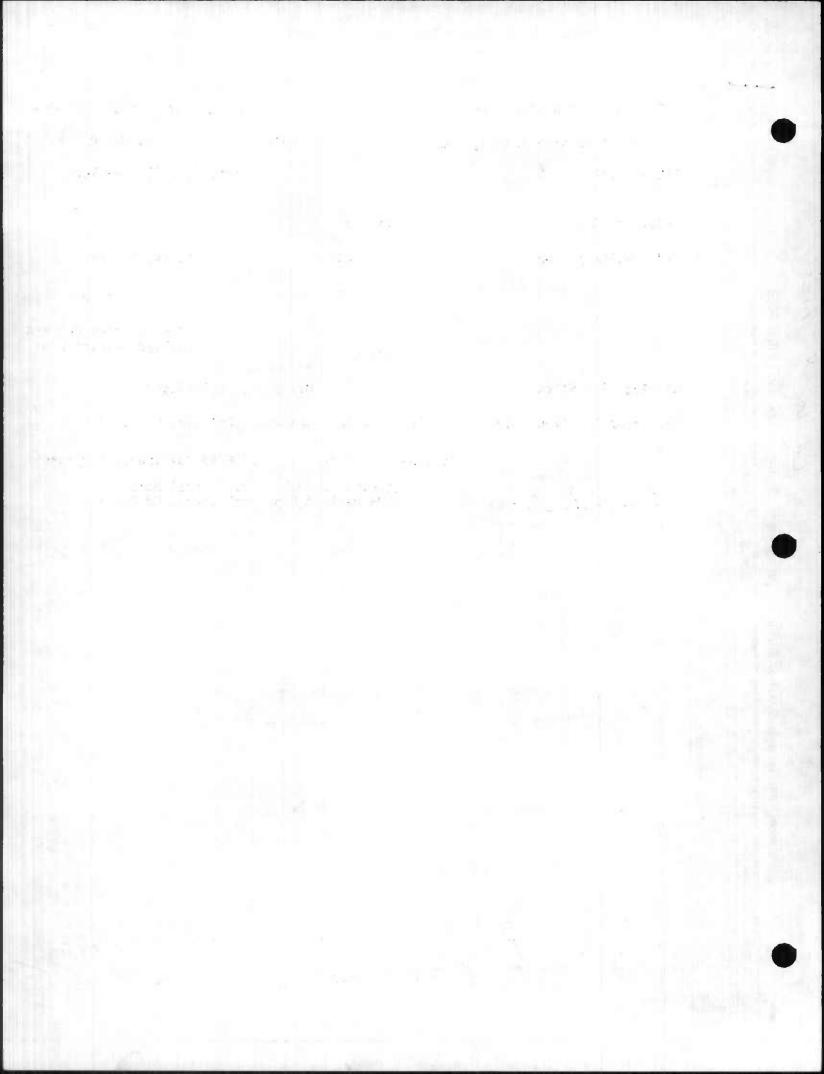
30. Name end address of person who completed cause of death (Item 23e) (Type, Rrint)

29d. Date signed (Month, Dey, Year)

altimore, Maryland 21215-0020

Box 68760,

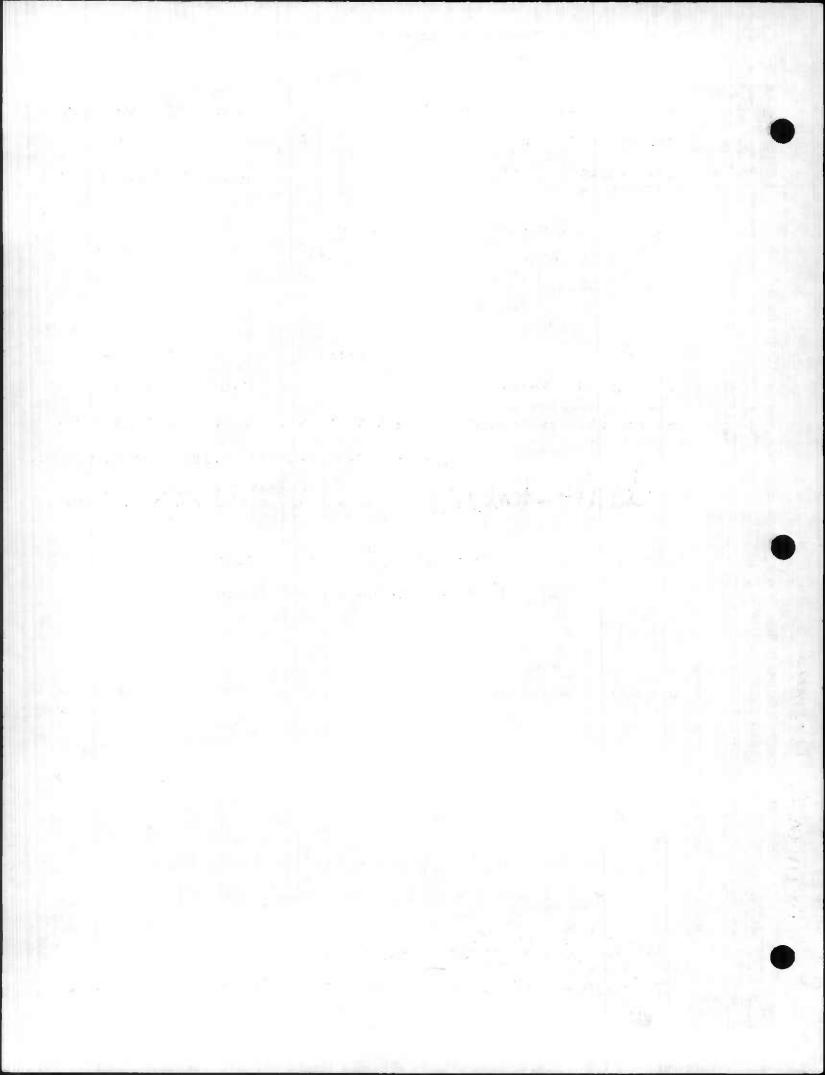
Division of Vital Records, P.O.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey Year Month **Physician** Thelma Katherine Reimers 1999 MARCH 10:17 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 75 1 M 3 TAF Yrs. 218-14-5348 Director Maryland 21 1923 March Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylen Department of Health and Mental Hygiens.
Important: If tem 27 is marked other than "naturel; or items 23a or 23a-f show eny injury or other traumatic event, fire Modical Exames man its notified as 1 ☐ Yes 2♥ No Director Maryland 10e. Streel and Number Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 1237 United States Voqt. Ave. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marilal Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 11 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Caroline E. Brown William Μ. Neale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Charles Reimers 1237 Vogt Ave. Arbutus, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If its eny injury or o pnce. 1 Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 3/16/99 Woodlawn, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21227 1328 Sulphur Spring Rd. Arbutus, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as e consequence of) ardio vasce Examiner attending physician and for use as the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Physician/Medical thal initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed peen cartificata has b lirector, page 2 s 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? PIMPRS Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No Aftar this 28a Date of Injury (Month, Day Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 10 Natural 5 Pending 1 TYes 2 □ No investigation eftar death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled In by 4 Homicide Dir 24 hours e 29a. Certifier (Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated. edical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie cause of death (item 23a) (Type, Print) 30. Name end address of person with compl Caton Ave, Baltimore, M heodore 600 artison 32. Registrar's Signature 681 31. Date filed (Month, Day, Year) State 1099 1 5 Registrar

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Veer Rich Lulu March 1999 MAZISI 10 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Baltimore Augsburg Lutheran Home Lochern Hours Min. 8. Dete of Birth (Month, Dey, Year, April 7 1 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Deys 1 ■ M 2 ■ X 91 047-18-8018 Vrs Connecticut 1907 Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Lochern 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6825 Campfield Road 21207 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Yes 2 No f Yes, Give White 1 ☐ Yes 2 ☑ No Specify: 3 □ Widowed 4 □ Divorced Yeer or Dates: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home n/a 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Leonard Petruccelli Philomena Agrella 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joanne R. Fleming/daughter 812 Ramshead Circle, Cockeysville, MD 21030 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State Balto. Wash. Crematory 3/15/99 Laurel, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Lemmon Funeral Home Signature of Puneral prervice License Lowell Lemmon 10 W. Padonia Rd., Timonium, MD 21093 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting In deeth) Carcinoma Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ASCVD 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 28. Plece of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 28b. Time of

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

10a State

MD

Funeral

Director

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at

6

"natural", or

permit. Pages 1 end 2 should be filed within 72 hours after Depertment of Health end Mental Hygiane. Important: If Item 27 is merked other than "natural", or ite

Baltimore, Maryland 21215-0020

with the Maryland

Physician/Medical Examiner attending physician and for use as the burief-trensit been signed be should be determined by the state of the signed by the state of the signed by the sig Completed by director. Be Certification: To funeral To the Hospital or pure within 24 hours after deeth.

To the Funeral Director: After the Funeral billed in by the fur

or Attending Physician: The law requires that the death certificate be executed

this

After

Box 68760,

Division of Vital Records, P.O.

1 Yes 2 4No 1 Raturel 2 Accident 3 Sulcide

25. Wes case referred to medical exeminer? 27. Menner of Deeth

4 Homicide

(Check only one)

29e. Certifier

Medical

5 Pending investigation

6 Could not be determined

Dete of Injury (Month, Dey Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Baltine MD

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steled.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) end menner steled.

29b. Signeture end tille of certifier

29c. License number 37573 29d. Date signed (Month, Dey, Year) Mach

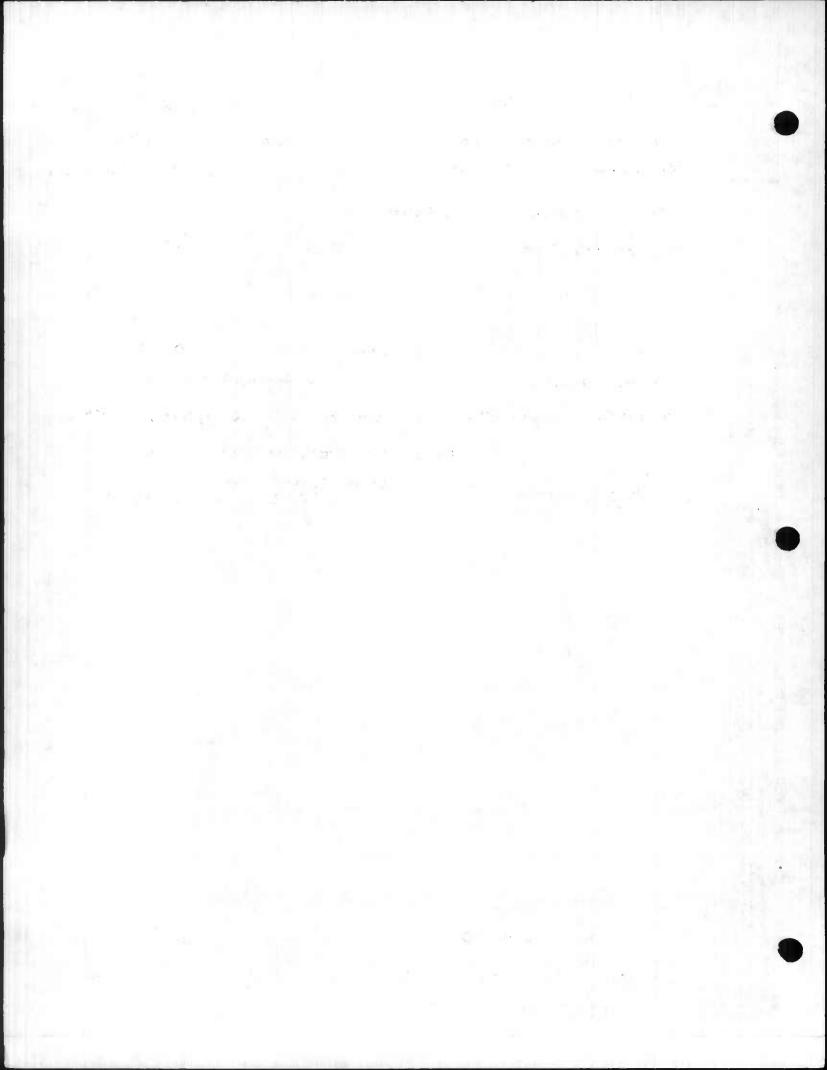
30. Neme and eddress of person w completed cause of deeth (Item 23e) (Type, Print) Zibell Park 7770

32. Registrer's Signeture 31. Date filed (Month, Dey, Year)

MAR 1 5 1999

Se company

State Registrar



	FOR
1 -	STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

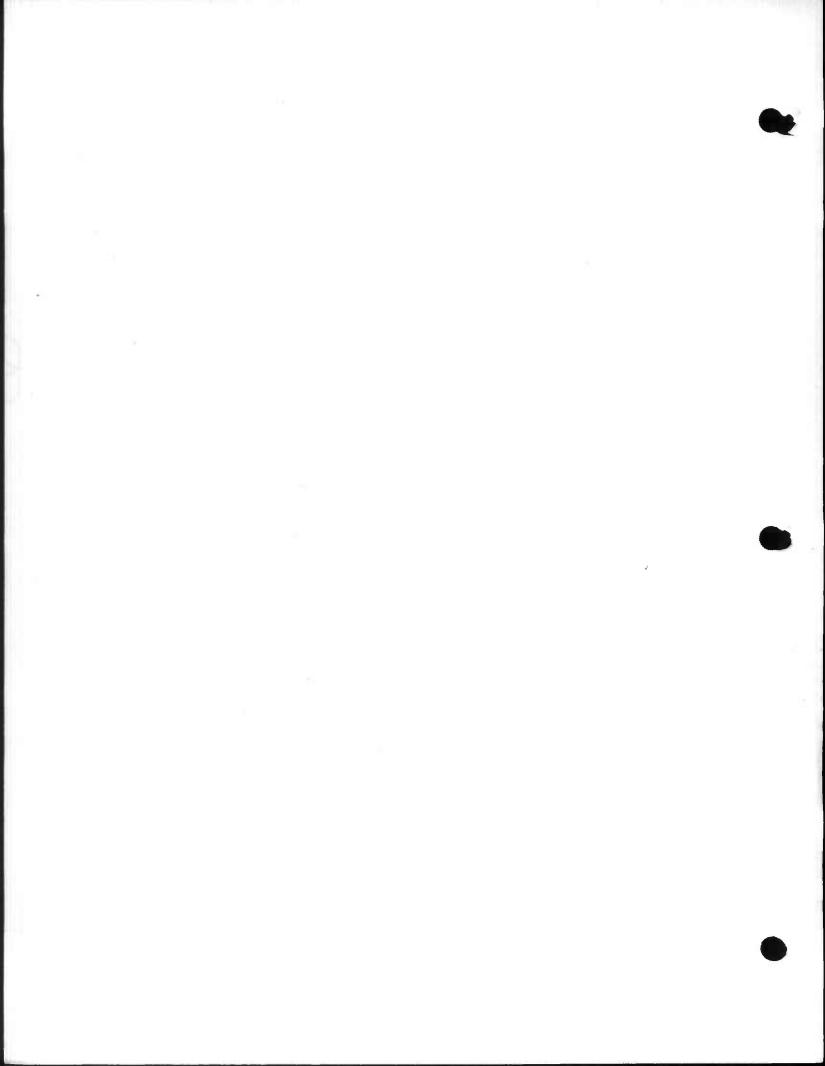
	REGISTRAR		CERT	TIFICA	TE OF	DEATH	RI	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last						2. DATE OF D	EATH			3. TIME OF DEATH
	Rachel S. Smi	th					03 -	07	-19	YEAR	8:00 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 8.	AGE (In yrs. last birth	day) IF U	NDER 1 YEAR	IF UNDER 24 HRS.	7 0475 05 0		- / /	6. BIRTH	IPLACE (State or Foreign
	213-03-8192	1 □ M 2 🙀 F	92 YF	IS." MONT	THS DAYS	HOURS MIN.	(Month, Day Sept.	24,	1906	Counti	ryland
	9a. FACILITY NAME (If not institution, give	street and number)		9b.	CITY, TOWN	R LOCATION OF DE			9c. COU	NTY OF D	EATH
DIRECTOR	The Wesley Home			1	Baltim	ore			Ba]	Ltim	ore City
5	RESIDENCE OF DECEDENT										
2	10e. STATE 10b. COUN				WN OR LOCAT	ION					10d. INSIDE CITY LIMITS?
		imore City	B	altir -	nore						1 X YES 2 NO
¥	10e. STREET AND NUMBER				101	. ZIP CODE					WHAT COUNTRY?
BY FUNERAL	2211 West Rogers	Avenue				21209			U.	S.A	
5	11. MARITAL STATUS	12. WAS DECEDENT E			13. WAS DEC	ENDENT OF HISPAN	NIC ORIGIN? (Sp	ecify Yes	or No-	14. RACE	E — American Indian,
<u>ب</u>	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE WAR				ecify Cuban, Maxica 2 NO Specify		etc.)		Speci	k, White, etc. Hy: White
	3 🔀 Widowed 4 🗌 Divorced					-74					WHILE
Ē	15. OECEDENT'S ED (Specify only highest grad	JCATION le completed)	18a. DECEDE	NT'S USUA	L OCCUPATIOns during mo	ON st of working	16b. KINI	OF BUS	SINESS/IND	USTRY	
Щ	Elementary/Secondary (0-12)	College (1-4 or 5+)				-					
호	8	0	Ope	rato	r		Te	1eph	none		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA					
BE	Joseph Thomas S	wann				Mary Wi	ilhelmi	na I	Hutch	ins	
2	19a. INFORMANT'S NAME (Type/Print)					nd Number or Rural I					
-	James Zimmerman	/nephew	1111	Ben	jamin	Road, Be	el Air,	Mar	cylan	d 21	.014
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Res	noval from State	20b. PLACE AND D			me of	DATE	20c. LO	CATION -	City or To	wn, State
	4 Donation 5 Other (Specify)		cemetery, cremetory	or other pr	ece)						
	Bonald S.	Wade Dir	ector		State	Ana Conv	Board.	655	5 W.	Balt	imore Street
	Y Amana	11/1/100	10			nore, Mar					
7	23. PARTIL Enter the diseases, or	complications that co	nised the death	4.5			-				(
- 1	ahock, or heart fallure	List only one ceuse	on sech line.	50 110(01	nei uie iiio	de or dying, euc	n as cardiec e	or reebii	ratory arr	eat,	Approximate Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	A 0 1	- 0-	0.0	^.	(m.	4				Onset and Death
	resulting in death)	a. HCUI	E RES	PIRA	1070	1-AIL	yre				7+CU1E
_ 1		// / / / / /	CAR								140
CERTIFICATION	Sequentially list conditions,	DUE TO (OF	AS A CONSEQUENCE		UMA						1400147
Ă	If any, leeding to immediate cause. Entar UNDERLYING										i
ᇤ	CAUSE (Disease or Injury that Initiated events	DUE TO (OF	AS A CONSEQUENCE	E OF):							-
분	resulting in death) LAST	4									
ᄬ		u.									
A	PART II. Other significant condition				underlying	cause given in	Part I. 24a.	WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DICAL	CORONARY ARTER	LY DISCHE	CHRONI	C	OBSTR	MOTIVE	1	YES 2			COMPLETION OF CAUSE OF DEATH?
ME	PULMONA	RY DISE	ASE					-			1 YES 2 NO
	DID TOBACCO USE CONT			YES [NO	UNCERTAIN	V X				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF								
S	EXAMINER?	HOSPITAL:	VOutpatient 3 DC		HER:	5 🗆 Residence	E Cother (Co.	-14.1			
<u>}</u> ן	27. MANNER OF DEATH	28a. DATE OF INJ	URY 26b.	TIME OF	28c. INJ	URY AT	26d. DESCRIB		NJURY OCC	URED	
	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,)	fear)	INJURY		RK? 'ES 2 NO					
BÁ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF IN	IJURY — At home, fa	rm, atreat,			281. LOCATION	(Street a	nd Number	or Rural F	Inute Number
COMPLETED	4 Homicide determined	building, atc.	(Specify)				City or Tow	n, State)	na mamba	or ribrar r	iooto rtanioo,
9	29a. CERTIFIER	WOLLD TO BE A SECOND									
2		ER: On the best of my									
8			manufact myself	gation, in i	пу ориноп, о	eath occured at the	time, data and p	olaca, and	d dua to the	n cause(s) and menner as stated.
#	286. PROPOSITION AND TITLE OF CENTIFIE	Colymn	Y			29c. LICENSE NUN	IBER -		29d. DATE	SIGNED	(Month, Day, Year)
2	30 NAME AND ADDRESS OF DEPOSIT	200/11/20	A DEATH STATE			D-174	<u></u>		- 3	181	77
	30. NAME AND ADDRESS OF PERSON W		ア DEATH (ITEM 27) (lype, Print)	(rns	M12-	P		MD.	~	10 o G
	31. DATE FILED (Month, Day, Year)	BY M.D.		, 15,00	FERS	AVE	NAL	10,	1119.	-	1207
	MAD 1 2 1999	32. REGISTRAR'S		1							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PHILLIP MARCH 7, 1999 2:35 PM /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON If Undar 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 218 14 93 44 8. Date of Birth (Month, Dey, Year) 3 /12/25 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** M 2□F Months Days Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Haalth and Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show ury or other treumetic event, the Medical Examiner is an be notified as 10a Stata 10h Counts 10c. City. Town or Location 10d. Inside City Limits ESSE 1 ☐ Yes 2 No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PLACE BRIAR HILL 4.5 2/22/ Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: BLACK by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Balto . Md. College (1-4or 5+) Eiementery/Secondary (0-12) PoLICC. NE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 5mith MAMIE EdGAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ballo. md. 21208 7903 Crisford PLACE Apt L ELLA MAR MYBHS 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Paga Department o Important: If i eny Injury or Cen, WoodLANN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatura of Funaral Service Licensea Tocks Josephy. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final 1 MONTH SPINAL CORD COMPRESSION SECONDARY TO disaasa or condition resulting in deeth) Examiner Due to (or as a consequenca of): Examiner PROSTATE CARCINOMA physician and tha burial-transit The law requires that the death cartificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): signed by the at d be datached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown METASTATIC PROSTATE CARCINOMA A 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy paga 2 s 1 Yes 2 No 1 Yes 2 No cartificata Hospital or Attending Physician: funaral director, 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To After this 28c. Injury et Work? 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural aftar daath. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI complataly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner es steled.

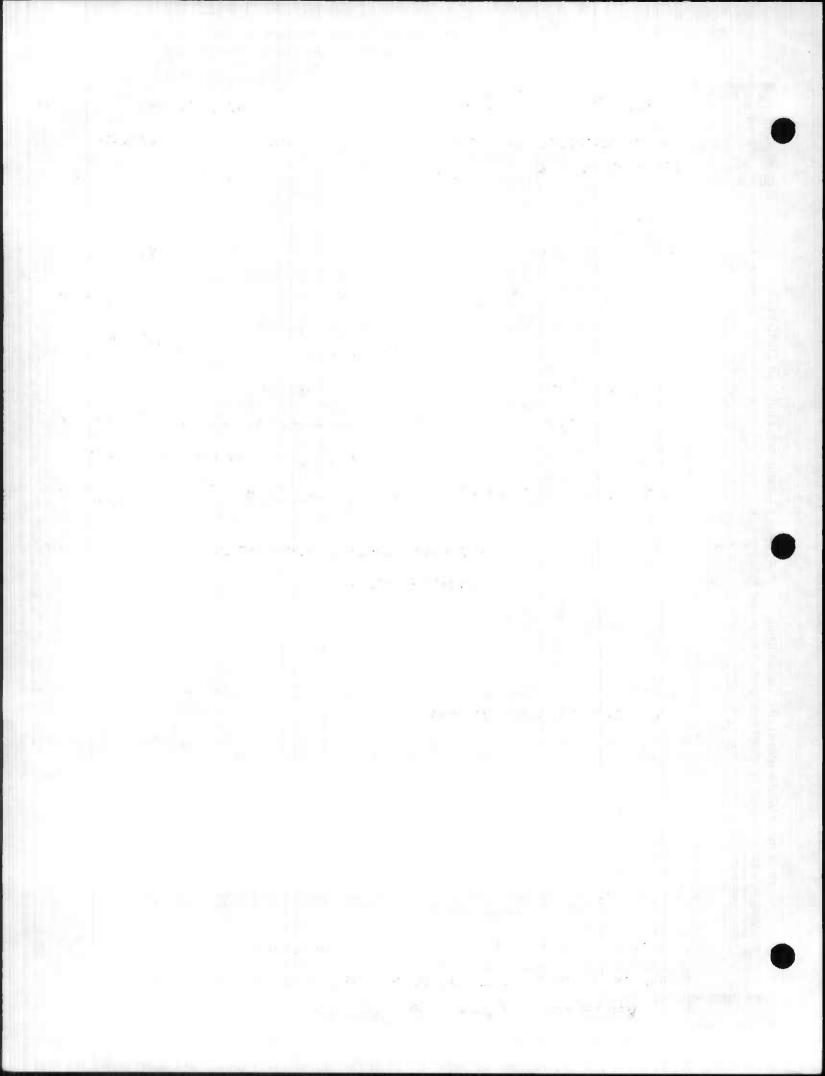
Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier m.O D 41410

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CARL F. 8 a.m. SPRIGGS March 11,1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1612 JOPLIN STREET BALTIMORE If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 234-60-2047 61 Director 5,1938 Virginia **Usual Residence of Decedent** 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits then "natural", or heme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD. N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1612 JOPLIN STREET 21224 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 UNO
If Yes, Give Year or Dates: 14. Race - American Indian. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Hygiene. ther then "netural", or he 1X Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahouid be filed wit Department of Health and Mental Hyglens Important: if item 27 is marked other than any injury or other traumatic event, that ance. 10 DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 GARNETT SPRIGGS LACY McCROSKEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES HUNT/SISTER 1614 JOPLIN STREET, BALTIMORE, MD. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARMEL CEMETERY 3/13/99 BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Finat 15 ano-The disease or condition resulting in death) Examiner Examiner uag attending physician and for use as the burial-transit The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by ti 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Other: 4 Nursing Home Statesidence 6 Other (Specify) 10 this. funeral 27. Mannar of Dedi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Director: After ti d in by the funera Certification: oepital or Attanding hours after death. 1 Metural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directomplately filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number ans PED 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 46chart Rd Glen Burne and 2106

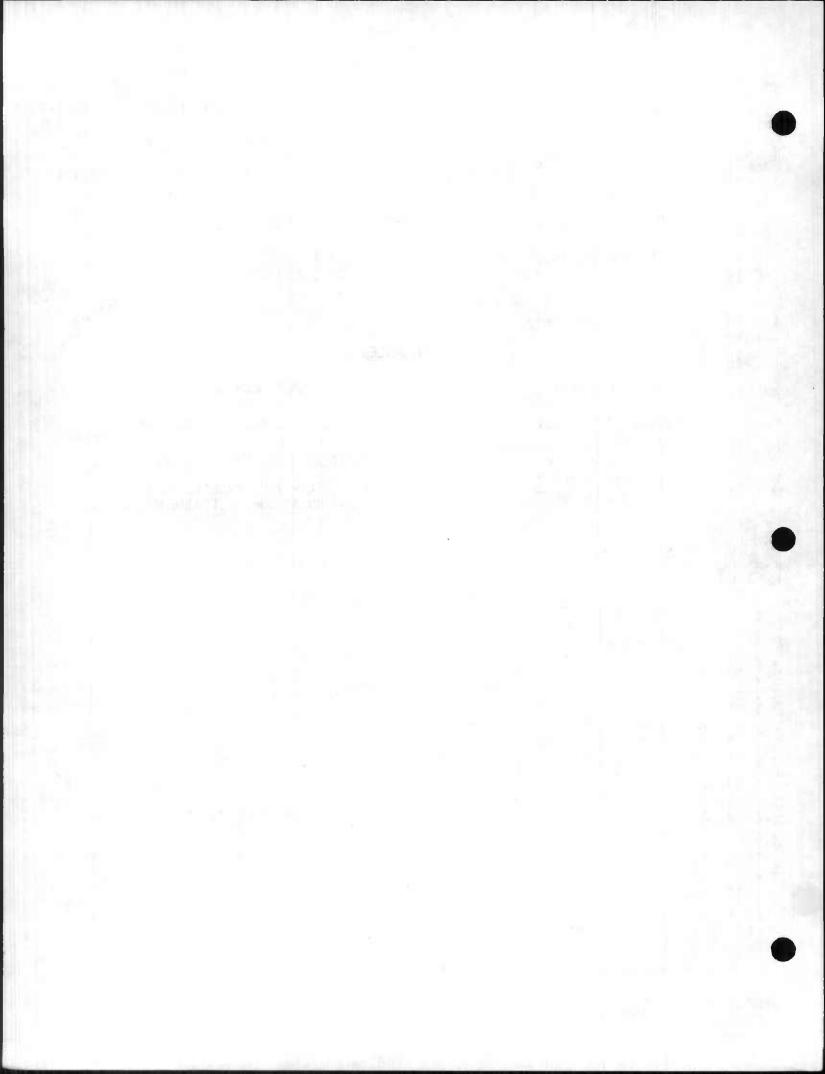
Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

32, Registrar'a Signature

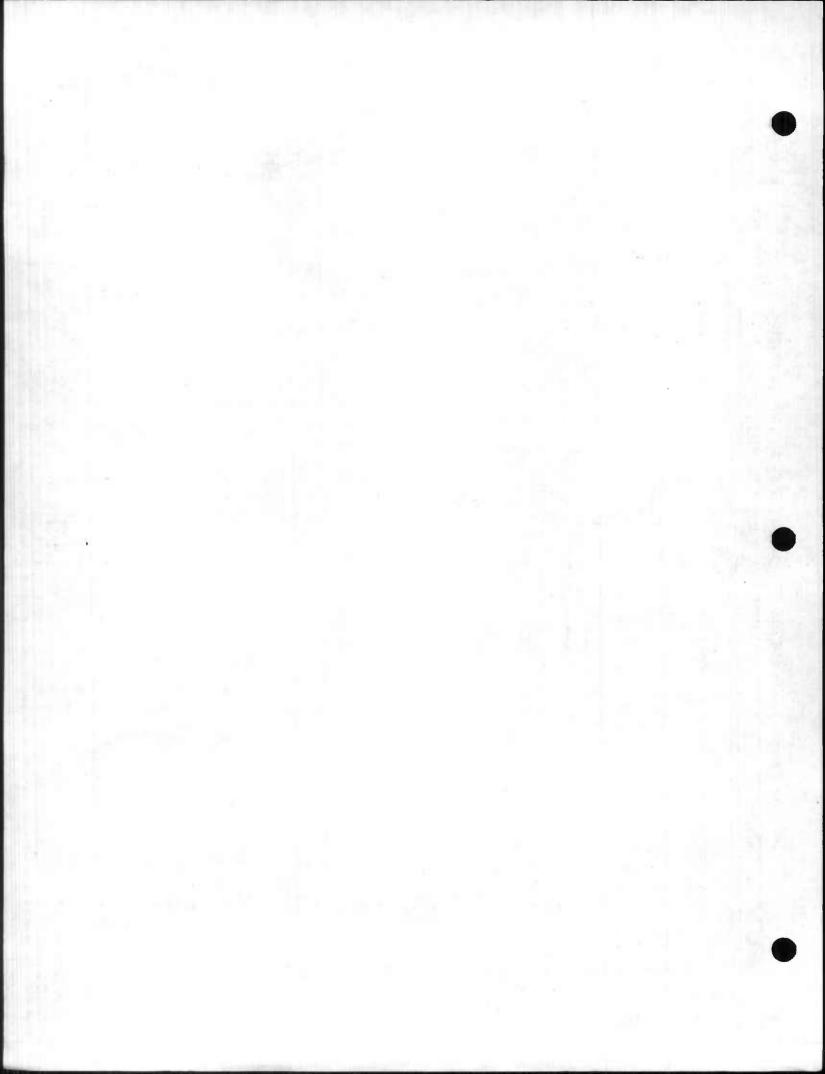
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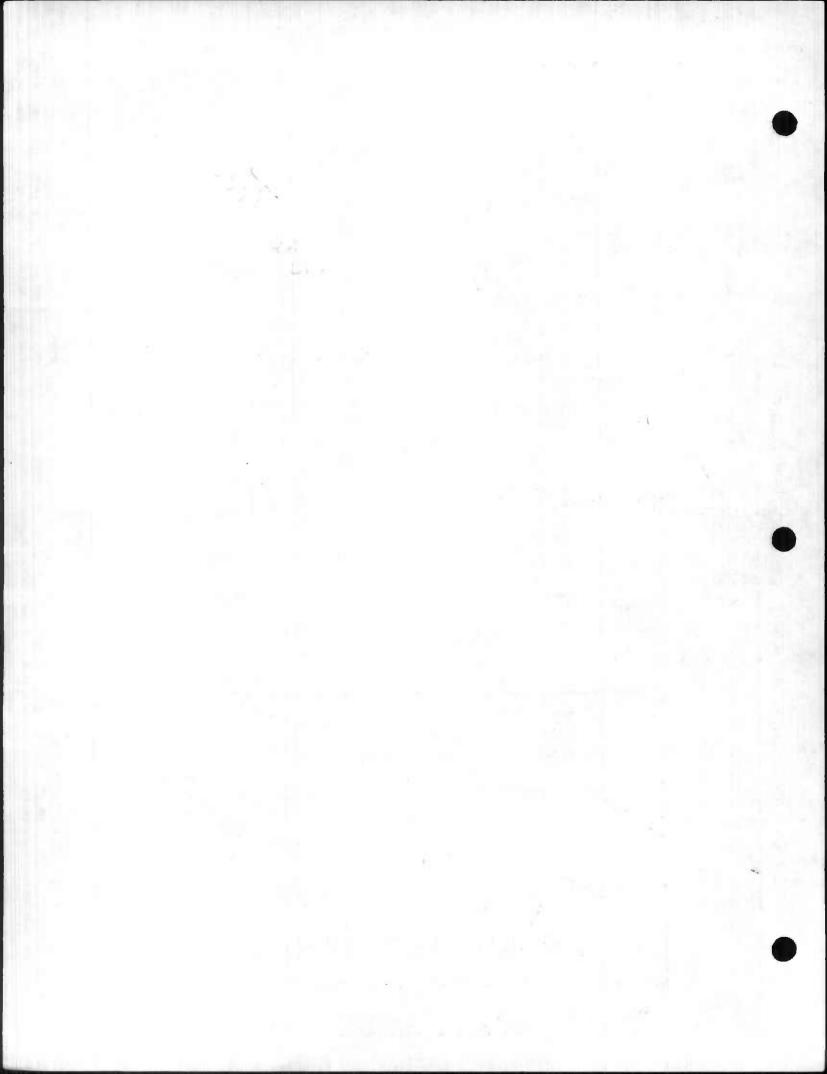
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	State of Maryland /	Department of Health and Mental	Hygiene ()	0808
Item: 26 per MD G-769 3		Certificate of Death	Pen No	0000

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			Sinai Hospital							Baltin	nore		n/a			
	Funeral		5. Social Security Number 6	. Sex			last birthday)	ff Under		If Undar Hours	24 Hrs. Min.	8. Data of Bir (Month, Da	th Voorl	9. Birthp	elaca (Stata or Fo	oraign
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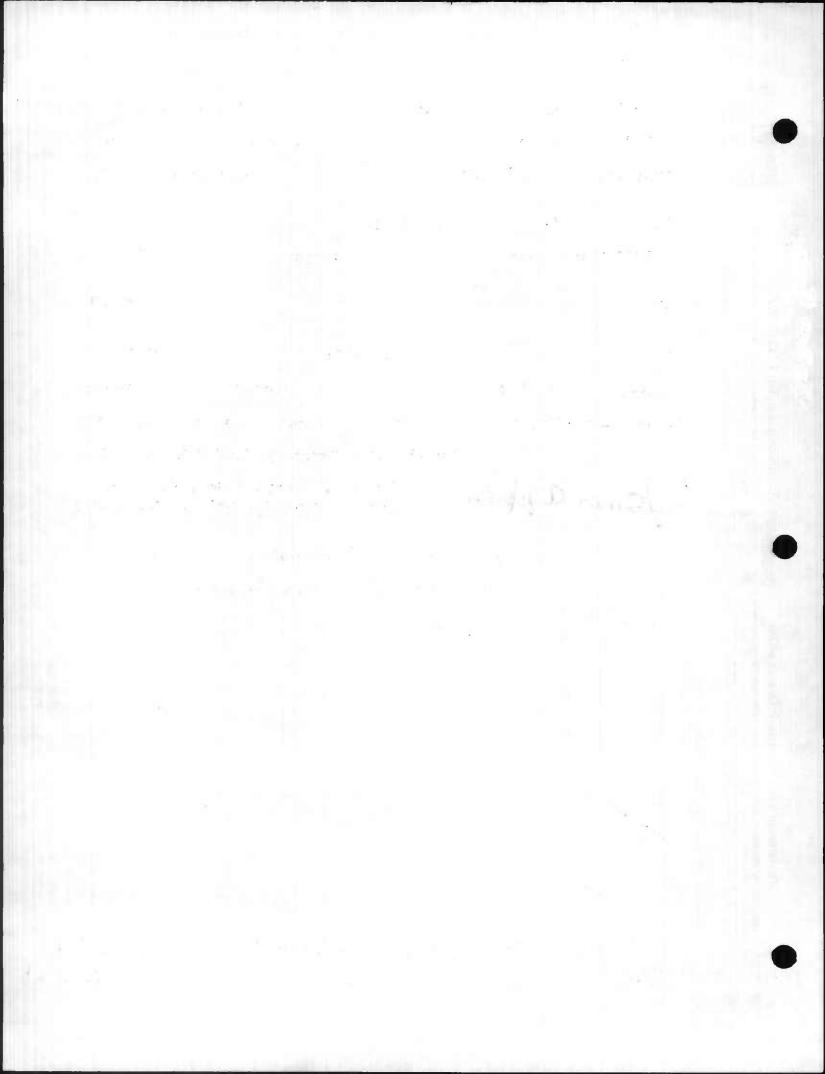
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		Jerance d	. Aaml	6 m	a, c	P	37203	3	March	, 13	1999
	;	30. Name and address of person who	completed cause of de	ath (Item	23e) (Type, Pri	nt)	A 110-	001		0	1
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Certificate of Death

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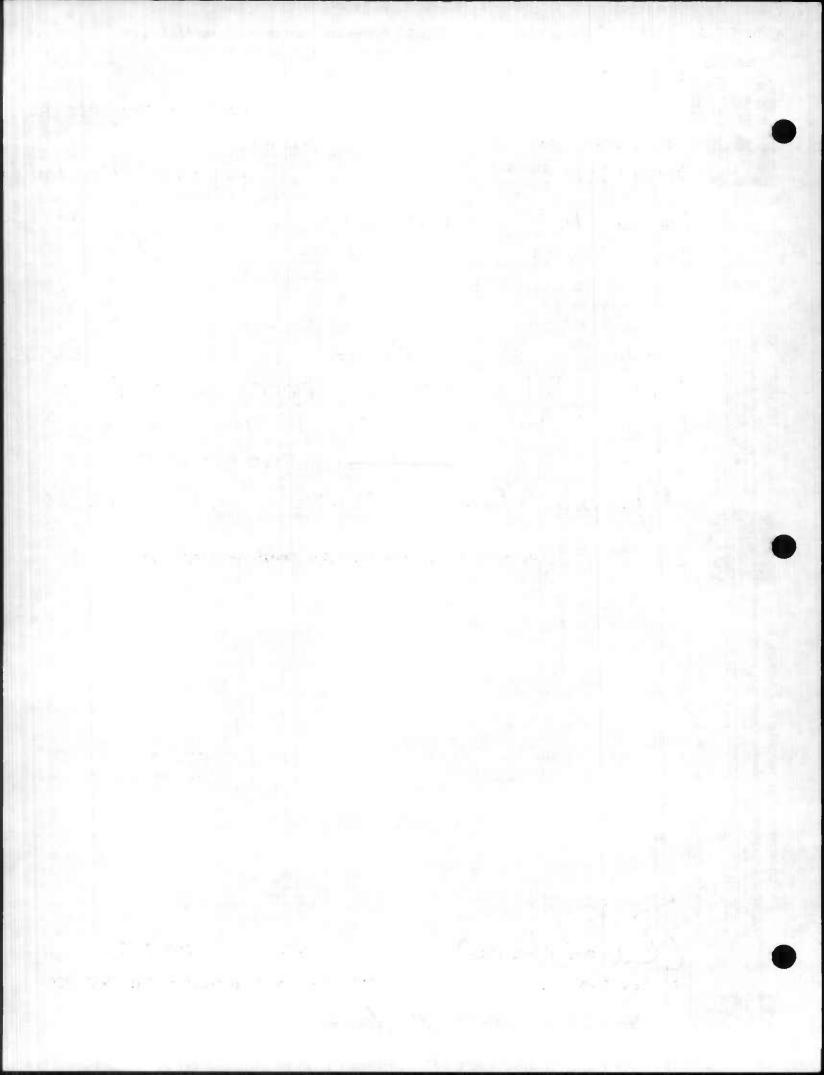


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	P.		Usual Residence of Decedent 10a. State 10b. County , 10c. City, Town or Location 10d. Inside City Limits							
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of	g Phys er this ieral d		27. Menner of Deeth	28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. [Describe how injury occurred		
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Division	or Attend after death Director: A		3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)		8f. Location (Street and Number or Rurel Route Number, City or Town, State)				
	ital or res afta res Dir sed in									
	To the Hospital or Attending I within 24 hours attar death. To the Funeral Director After completely filled in by the funer	edicai	1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end mannar as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
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	F 3 F 8		(N) 01 - 100 - 100			O.C.M.E.		MARCH 12,1999		
			30 Hame and address of person who co	ompleted cause of death /ltm		C.Pl.E.	MAIN	Cn 12,1	777	
			J. Laron Locke M.I			nn Street,	Baltimor	e, Marv	land 21201	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa				1		

Registrar

MAR 1 5 1999 Some B. Sports



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death ITEM: #26 PER MD G769 3-12-99 WR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 26, 1999 **Physician** Barbara Ann Whitehair 3:40 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 369 Holly Trail 8. Date of Birth (Month, Day, Year) Crownsville Anne Arundel If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Hours Months 1□ M 2□ F 217-50-8301 Yrs. 50 Director Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 7 is marked other than "natural", or frame 23s or 28s-f show traumetic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 369 Holly Trail 21032 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Marital Status pernit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if tem 27 is marked other then "natural", or free important: of the result of the result of the result of the result. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Ruby Lee Wilkins Walker Buford Nelson Stallard 0 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Bob T. Whitehair/husband 369 Holly Trail, Crownsville, Maryland 21032 20b. Plece of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee, Ronald S Wade, Director State Anatomy Board, 655 W. Baltimore Street Delle Baltimore, Maryland 21201 Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner colonor ante physician and s the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) US0 25 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? dependent 1 Yes 2 No 3 Probably 4 Unknown Records, þ Be Completed 24b. Were autopsy findings evailable prior to 24a. Wes en eutopsy performed? completion of cause of death? page 2 s 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificate of Vital Attending Physician: director, 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home (\$ Residence) 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Division After 1 Netural 2 Accident 5 Pending 1 Yes 2 No 24 hours after death. investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide 8 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. edical 29a. Certifie within 24 ho To the Fune completely fi (Check only one) \$ the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 99 D38188

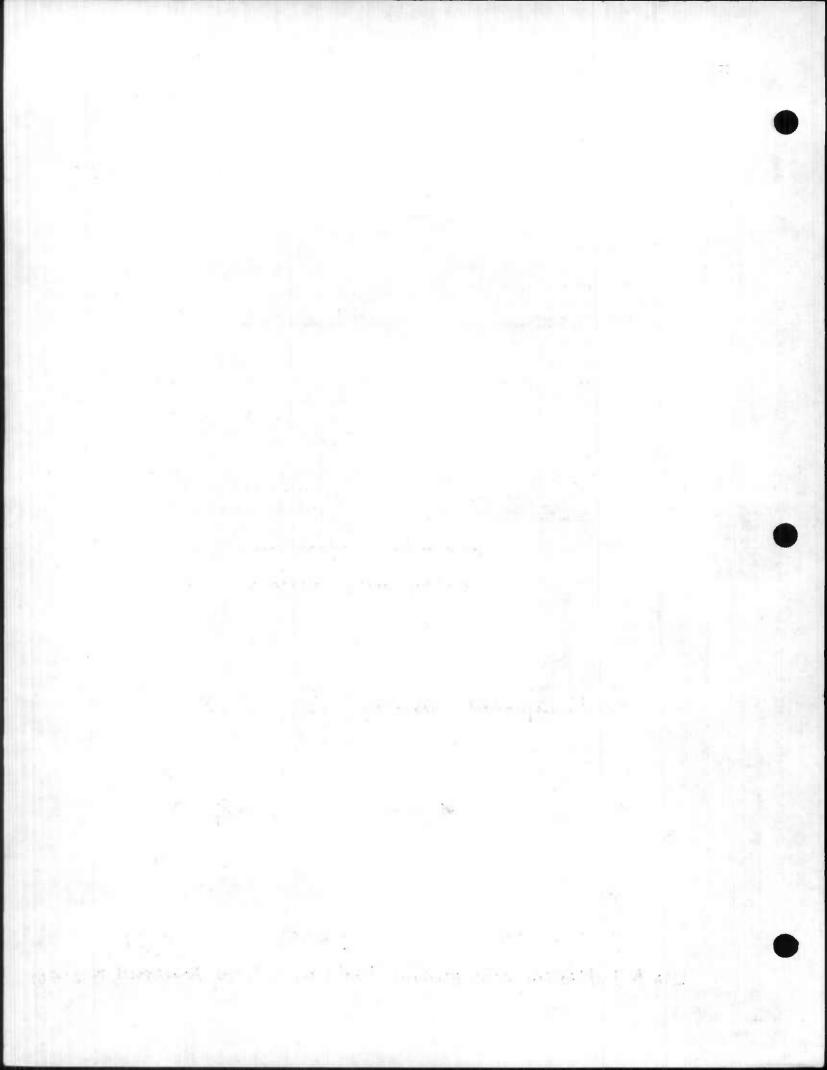
State Registrar

31. Date filed (Month, Day, Year) MAR 1 2 1999 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

LISA A D/MARCID, 2003 Medical Parking

Suit 100, ANN APOLIS, NO 21401

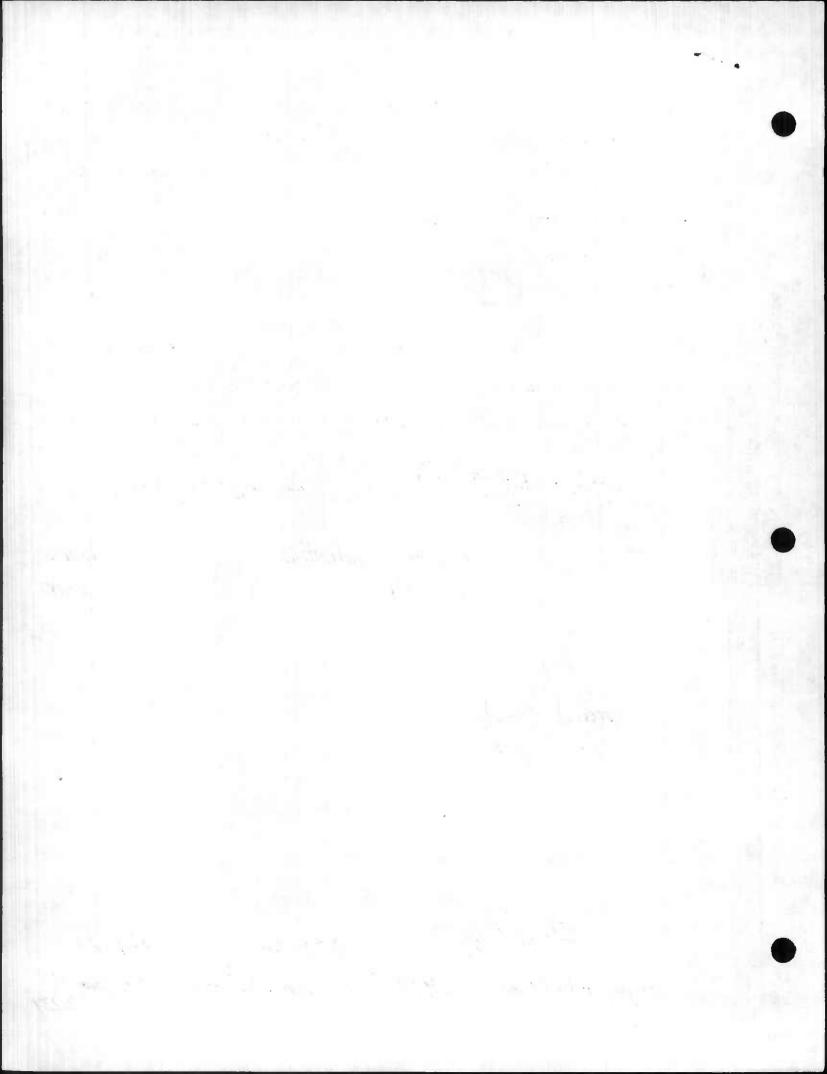


State of Maryland / Department of Health and Mental Hygiene

•	Certificate of Maryland / Department of	
Physiciar /Medica	Joseph John Waldsachs	2. Date of Death Month Day Year March 10, 1999 8:34 PM
Examine	4a Facility Neme (If not institution, giva street and number) Franklin Square Hospital	4b. City, Town, or Location of Death Rossville Raltimore
Funeral Director	5. Social Security Number 220-20-1624 6. Sex 1X M 2 F 7. Age (In yrs. last birthday) F Under 1 Yes Months Day Usuel Residence of Decedent	
with the Maryland a or 28a-f ahow	10a. Stele 10b. County 10c. City, Town or Location	10d. Inside City Lim
the Mar 28s-f al	Maryland Baltimore Parkville	1 □ Yes 2 🕅
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d 2 should th and Mer 7 ie marke treumatic		et and Number or Rural Route Number, City or Town, Stete, Zip Code)
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permit. Pages 1 at Department of Hea Important: If them; any injury or other page.	21. Signature of Funeral Service Licensee Timothy Harman 22. Name and Add Leonard	
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	sleep aprea	24a. Wes en eutopsy performed? 24b. Were autopsy finding available prior to complation of cause of death?
Physicien: The law requires this certificate has been signeral director, page 2 should be completed by		1 Yes 2 No 1 Yes 2 No
Physicien: this certific ral director,	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 tnpatient 2 ZER/Outpatient 3 DOA	26. Place of Death (Check only one) Nther: 4□ Nursing Home 5□ Residence 6□Other (Specify)
or Attending Physical design of the fundant of the		
Date de la compansión d		City or Town, State)
To the Hospital or within 24 hours aft To the Funeral Dir completely filled in Medical Cert	29e. Certifier 1 Certifying Physician: To the best of my powledge, death occurred at the (Check only one) Medical Examination on the basis of examination and/or investigation, in my one)	time, date and place, end due to the cause(s) and menner as stated. opinion, death occurred at the time, date end place, and due to the cause(s)
To the complex	2/1 1/1/11/11	nse number 29d. Date signed (Month, Day, Year)
	> selles 0	32939 3/12/99
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	TODA DA #102 BAlham MA
State	31. Date filed (Month Day, Year) 32. Registrar's Signature	11) JULY (10) 11/1/10/10/10/10/10/10/10/10/10/10/10/10
Ponistrar	Attan a la l	CICSY

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month GOWARD F. WELCH 28 3:30 Pm 4a Facility Name (ff not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death CINIZCH INSPITAL BATEMORE Baltimore City | Months | Days | Hours | Min. | S. Date of Birth | S. Date of Birth | Pay Year | Oct. 11, 1921 | S. Birthplace (St. Country) | Oct. 11, 1921 | Unknown 9. Birthplace (Stete or Foreign 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) 1₽M 2□ F 216-18-3628 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore City Maryland 1 Se Yes 2 No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1046 Old North Point Road 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?unknown 1 ☐ Yes 2 ☐ No If Yas, Giva 14. Race - Amarican Indian, Black, White, etc. Never Married 2 Married Specify: White 1 ☐ Yas 2 ☑ No Specify: 3 Widowed 4 Divorced Yaar or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) unknown 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other plece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Puneral Service Licensee Konald S. Wade State Anatomy Board, 655 W. Baltimore Street Director 1 Wille Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disaase or condition resulting in death) PULSELESS ELECTRICAL 10 MINUTES PULDWATEN EMADUS AWTS Bormma co Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Primoria 24b. Were eutopsy findings available prior to 24a. Wes an eutopsy performed? SEPSIS completion of cause of death? VRINARY TRACT INFECTION 1 ☐ Yes 2 No 1 Yas 20 No 25. Was case raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

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The Funeral Director: A stely filled in by the

To the Hosp within 24 ho To the Fune completely fi

death.

Certification: To

Medical

Box 68760

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Attending Physician:

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3/DZ00 after

Baltimore, Maryland 21215-

Examiner Physician/Medical þ Completed 8

examinar?

27. Manner of Death

Natural

2 Accident

3 Suicida

29a. Certifier

4 | Homicide

Hospital: 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yas 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner as stated.

N GROWN BAZTIMORES MOD ZIZZI

28d. Dascribe how injury occurred

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and mannar stated. 29b. Signature and title of certifier

5 Pending investigation

6 Could not be

29c. License number D36974

29d. Date signed (Month, Dey, Year) 13B 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID O. MANTON

31. Date filed (Month, Day, Year) MAR 12

32. Registrar's Signature

State Registrar



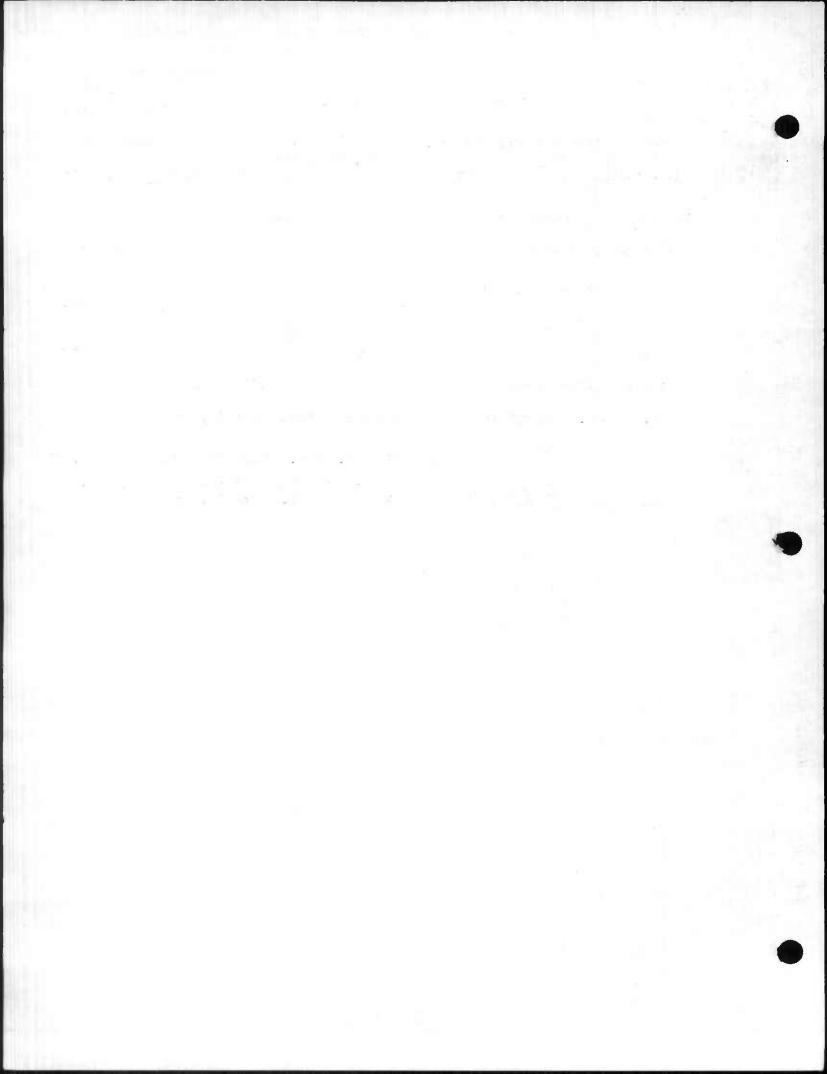
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth Day **Physician** Month Oather Jackson Warren, Sr. March 7, 1999 1:50 PM /Medical 4a. Fecility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis Eldercare Heritage Ctr. Dunda1k Baltimore If Under 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplece (Stata or Foreign Country) **Funeral** 1**□**M 2□ F Deys Yrs Director July 16,1921 Virginia 224-18-6569 the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at Director Dundalk 1 Yes 2 No Maryland Baltimore 10e. Street end Numbar 10f. Zip Code 10g. Citizen of What Country? 2005 Inverton Road 21222 United States "natural", or items 23a Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Dacedent of Hispenic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 □X/es 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced White WII Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: if Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Millwright Steel Industry 7 Years 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Homer William Warren Lilly Kern 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Iris H. Warren/Wife 2005 Inverton Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 50 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Holly Hill Mem. Gdns. 3/10/1999 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, of complications that causad the death. Do not anter the mode of dylng, such as cardiac or respiretory errest, shock, or heer railure. List only one cause on each line. Approximate Intervel Between Onsat end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) CEREBROVASCULAR ACCIDENT Examiner Examiner ettanding physician and for use as the bunal-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest EPZESCI OM

Due to (or as a consequence of): Records, P.O. Box 68760, Physiclan/Medical THEROSCLEROTIC HEART DISEASE Pert II. Other algnificent conditiona contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Onknown AMEMIA þ 24b. Were eutopsy findings aveileble prior to completion of causa of deeth? Be Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 20 No 25. Was case referred medical examiner? 26. Piece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA To the Hospital or Attanding Physi-within 24 hours after death. To the Funeral Diractor: After this c completaly filled in by the funeral dir 27. Menne of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1- Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide 29a. Certifie The certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end manner stated. 29b. Signature end title of certifier 29c. Licansa number 29d. Date signad (Manth, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) rulce Day. Year) State Registrar

WARREN

DATHER



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Mar Ne 100 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of De Examiner 8 Beehive Place Cockeysville Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) 5. Sociel Security Number 6 Say 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys 1□M 2XF Months Yrs. 217-01-6266 80 Director Maryland June 14 1918 Usual Residence of Decedent 10c. City, Town or Location 10a Stete 10h County 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylan nent of Health end Mentel Hygiene. Int: if them 27 is marked other than "natursi", or frems 23a or 28af show my or other traumatic event, the Medical Examiner must be noticed at 1 Yes 2 No Director MD Baltimore Cockeysville 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 8 Beehive Place 21030 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes, 2 ☐ Yoo If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, 11. Meritel Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 Yes X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) n/a Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Adam Zurell Lottie Taylor 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Wayne N. Wright/Son 3616 Sweetair Road, Phoenix, MD 21131 20b. Piece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 3/12/99 Department of Important: If any Injury or 4 Donetion 5 Qther (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21093 a Runaral Service License 22. Neme end Address of Fecility Signature Lemmon Funeral Home Lemmon MAK Lowell M. 10 W. Padonia Rd., Timonium, MD 21093 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** ardo Renal /Medical Immediate Ceuse (Finel diseese or condition resulting in death) 1030 Examiner Examiner ettending physicien end for use es the buriel-trensit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequenca of): signed by the e Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Tes 2 No 3 Probably 4 tonknown þ 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Was en autopsy peen page 2 1 ☐ Yes 2 ☐ No 1 Tyes 2/2/100 certificete director. 25. Wes case referred to medical Be 26. Piece of Death (Check only one) exeminer? 1 1 Yes 2 No Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 1 Maturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

The law requires that the death certificate be executed P.O. Box 68760. Records. Division of Vital Hospital or Attending Physician: 24 hours efter death. filled in by To the Hospi within 24 hou To the Funer completely fil

with the Maryland

altimore, Maryland 21215-0020

State

edicai

29a. Certifier

(Check only one)

29b. Signature end title of certifier

200

Registrar

MINE/MI) 31. Dete filed (Month, Day, Year) MAR 15 32. Registrar's Signeture 1999 · partie

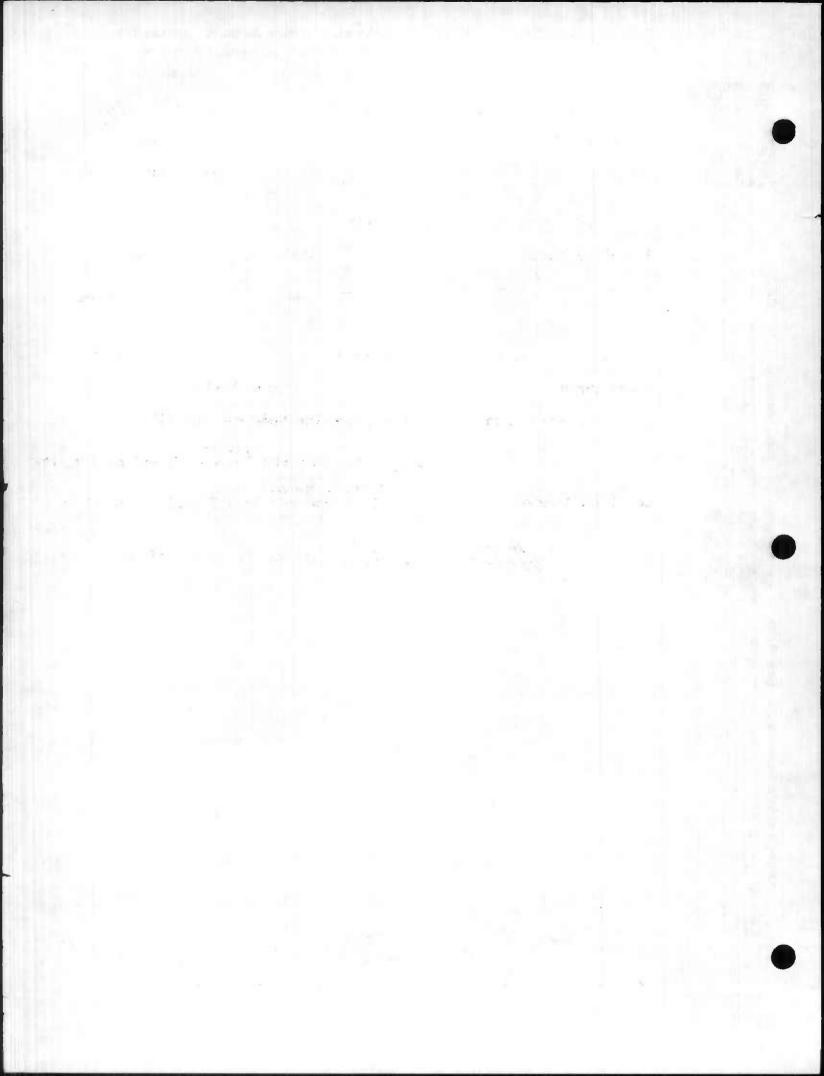
30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end manner stated.

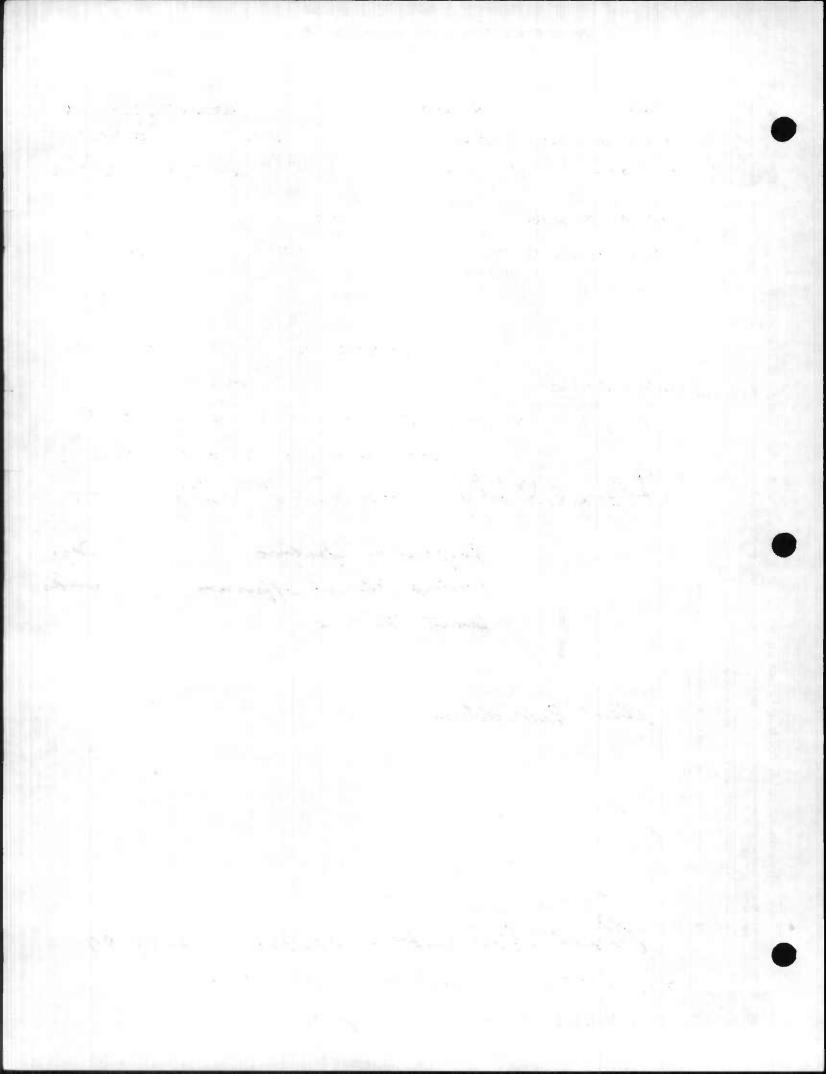
29¢ License number

29d. Dete signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dey **Physician** Ruth Alexander February 26, 1999 8:35 P.M /Medical 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | June 18, 1907 5. Sociel Security Number 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months 215-36-6206 91 Yrs. Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, ma Medical Exercises must be not if an anone. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₺ No Mt. Airy Directo Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 U.S.A. 13901 Glissans Mill Rd. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 Never Married 2 Narried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) private duty practical nurse 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middla, Last) Louisa Klein Charles Schneider 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 13901 Glissans Mill Rd. Mt. Airy, MD 21771 Clifford B. Alexander/husband 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 3/2/99 nr. Mt. Airy, MD Locust Grove Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Furgeral Sarvice License Jarine Libertytown, MD 21762 11802 Liberty Rd. 23e. Pert1. Enter the disease, or complications that could be the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on the respiratory errest. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificete be executed physician and the burief-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in deeth) Last Dua to (or as a consequence of) attending pl signed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Februlation by 24b. Were eutopsy findings available prior to completion of cause of death? ieted 24a. Wes en eutopsy performed? been Compi pege 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate director Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 Tyes 2 No 1 ☑Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this funerel 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of Certification: 28c. Injury et Work? After or Attanding 1 Naturel 5 Pending investigation 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Straat end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) à 4 ☐ Homicide Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, deta and place, and dua to the cause(s) end menner es steted. edical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signature of title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 026499 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 4 Culwell Dr. Mt. Airy, MD 21771 Ronald E. Miller 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Geneva Registrar MAR 0 2 1999

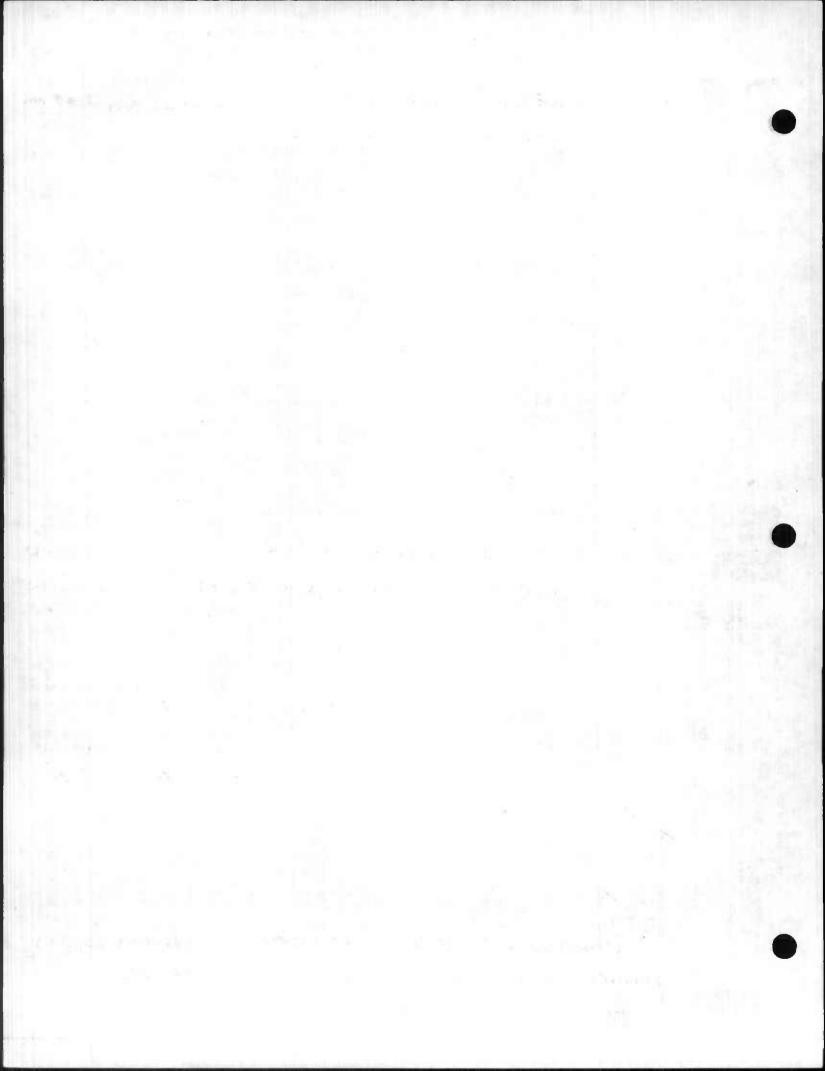


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

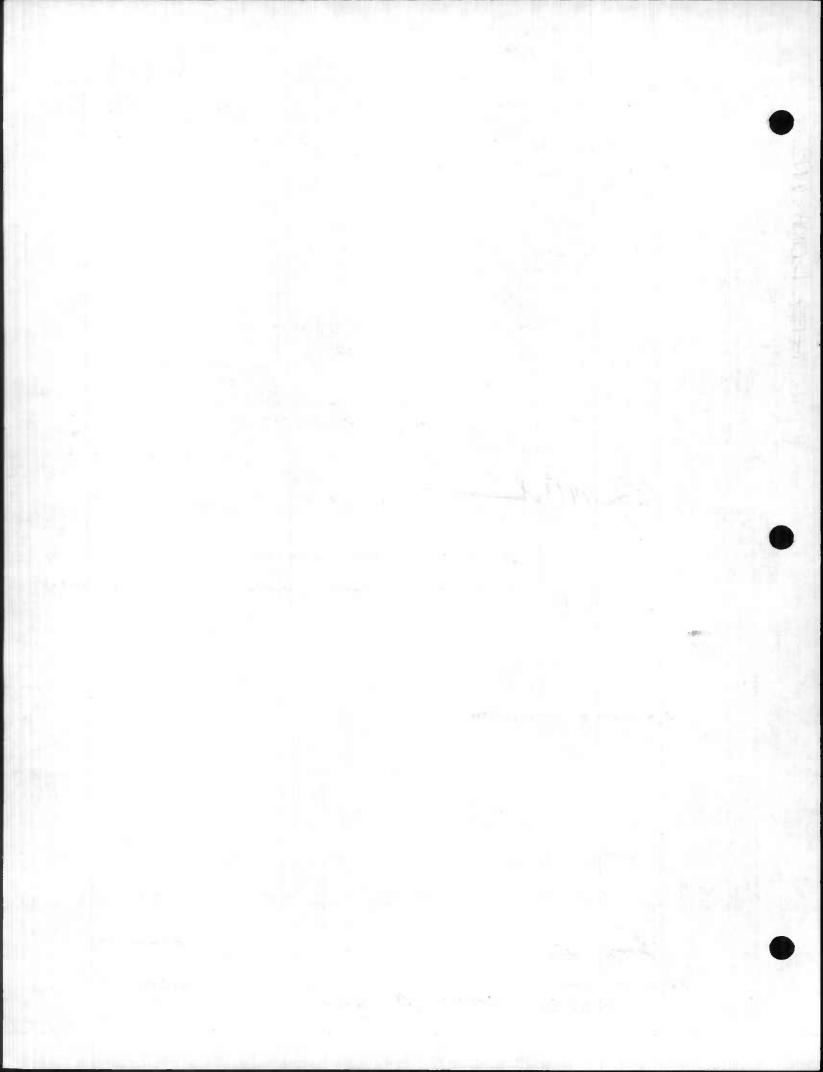
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				Ce	rtificate	of Deat	h	Re	g. No.9 9	0 8	3096	
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	/Medical Examiner	4e Fecility Neme (If not institution, gi	ve street and number)	771920				CTTY	4c. County	of Death	3.20	
	Funeral Director	5. Social Security Number 6.		rs. last birthday) Yrs.	If Under 1 Y		er 24 Hrs.	8. Date of Birth (Month, Day, NOV 28,	Year) 1923	Coun	place (State on the state)	r Foreign
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	ifier deeth with the Mai r Hema 23e or 28e-f a fine man be notified Funeral Director	10e. Street and Number 2003 Arabian Dri	ve		10f. Zip Co		.048	10	g. Citizen of US		itry?	
020	by by	11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent If Yes, specify			cify Yes or No- Rican, etc.)		ce - Americ ck, White,		
21215-0020	d within r than r than r	15. Decedent's E (Specify only highest gi Elementery/Secondary (0-12)		(Give	dent's Usual On kind of work do DO NOT use n	one during ma atired)		ng 1	6b. Kind of B			
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Ball	permit. Pag Depertment Important: I any Injury o pnce.	21. Signeture of Funeral Service Lice	W Ella	· 2	2. Name and A		El	ine Fune , Hampst			074	
Box 68760,	Centificate be executed ding physicien and use as the burial-transit as the burial as the burial physician and burial as the burial physician and the burial phys	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. MYOCA Due to	(or es a conse	quence of):			7101		1	12 HO	ek2
P.O.	that the death ce ed by the attendi detached for use y Physician/	Pert II. Other significant conditions	contributing to death but not r	esulting in the u	inderlying caus	e given in Par	t I.	23b. Did tot	1		bebly 4	
Records,	been sign should be							24a. Was an perform		80	ere eutopsy f ailable prior to mpletion of c death?	io
Itai B	ician: The law certificate has rector, page 2 Be Comp	25. Was case referred to medical				26. Pla	ce of Death	1 ☐ Ye	-	- 10	Yes 2	No
Division of Vitai	Attending Physic deeth. Sector: After this by the funeral di	examiner? 1 Yes 22No 27. Manner of Death 1 Neturel 5 Pending investigation 2 Naccident investigation 3 Suicide 6 Could not a determined determined	28a. Date of Injury (Month, Day Year)	home, farm, st	M 28c.	Other: 4 1 Injury at Work? 1 Yes 2	Nursing Ho	me 5 Resider 28d. Describe hor 28f. Location (Str. City or Town,	nce 6 □Oti w injury occur	rred		nber,
۵	To the Hospital or within 24 hours after To the Funeral Dir complately filled in Medical Ceri	(Check only 2 Medical Exa	nysician: To the best of my k	nowledge, deat	h occurred at the	e time, date	and place, a	and due to the ca	use(s) and m	enner as st	tated.	s)
	To the vithin 2 To the compla	29t Signature end title of certifier 30. Neme and address of person who	completed cause of death (It	M.D.	2E	S-C	000		B2UA	RY :	25,199	49 2128
	State	DANIEU 31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature			14七17	72 (A):	PITA	11		
	Registrar	MAR 0 2 19	99 Beneva	<i>D</i> .	Spar	Ksl						



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			Certi	ficate of	Death		Reg. No.	0005		
Dhuaisian	1. Decedent's Neme (First, Middle, L	ast)			318	2. Date of		3. Time of	Death	
Physician /Medical	Leona Jane	Byers				MAR	CH I	1999 1515	7	
Examiner	4e Facility Neme (If not institution, gi					vn, or Location of I		ty of Death		
	Washington Coun	•		If Under 1 Year	Hagers			ashington		
Funeral Director		4 DM OFFE		Months Days	Hours	Min. B. Date of (Month)	17, 1919	9. Birthplace (State of Country) Pennsylvar	n i a	
pung and	10a. Stete 10b. County	10c. C	ity, Town or Local	tion				10d. Inside Ci	ity Lim	
with the Maryland to or 28a-f show be notified at Director	Maryland Wash	ington	Will	i amspor	†		10g. Citizen g	1)(1) Yes f What Country?	2	
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in 72 hours after death v * "natural", or flems 234 fedical Examiner must oleted by Funeral	11. Meritel Stetus 1 □ Never Merried 2 □ Merried 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		es, specify Cubi		jin? (Specify Yes o , Puerto Rican, etc	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White			
ed within 72 ho ygiene. wr then "naturn 4, the Medical.] Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give kin	nt's Usual Occup	during most	of working	16b. Kind of	Business/Industry		
De Man	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired	7)			0		
	17. Father's Neme (First, Middle, Las	4)		Owner	40 Method	de Name (Cast Af	della Maidan Como	Grocery		
BEER O	Charles Edward	McCauley			Sara		ddle, Maiden Sums Timmons	unej		
EDEE	19a. Informent's Neme/Reletionship	(Type, Print)	19b. Mailing	Address (Street	and Number	r or Rural Route N	umber, City or Tow	n, State, Zip Code)		
	Rollin E. Byers/	Son	18 Nor	th Cono	cochea	ague Stre	et Willia	amsport, MD	2	
20元年で	20e. Method of Disposition 1 X Burial 2 Cremetion 3 E 4 Donetion 5 Other (Special Control of Cont	Removel from State	Plece of Dispositi cemetery, cremeted dar Lawn	tory or other plac		Date -k 3-3-99		- City or Town, State town, Mary I ar	nd	
Department in important: if any injury or itses.	21. Signeture of Funerel Service Lice	deed luc		lame and Addre			Williams	21 port,Marylar	179 nd	
The law requires that the death certificate be executed at the standing physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b. Anteniocc. Due to ((or as a consequence or es e consequence or es	(+FRC)	015	ens E		YEAR	**	
v requires that the death certi been signed by the attending should be detached for use a should by Physician/M	Pert II. Other algorificant conditions	dcontributing to death but not re	sulting in the unde	erlying ceuse giv	en in Pert I.	236.	Did tobacco use o	contribute to the cause of	of de	
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The lay							1□Yes 2ŒNo	1 Yes 2	No	
ysician: The is certificate he director, page	25. Wes case referred to medical examiner?				26. Place	of Death (Check o	nily one)			
this ce al dire	1 Yes 2 Ho	Hospitel: 1 Umpatient 2	ER/Outpetient	3□ DOA Oth	4 LI NUI	rsing Home 5	Residence 6 🗆 0	ther (Specify)		
To the Hoepital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification platesty filled in by the funeral director, Medical Certification: To Be (27. Menner of Geth 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - At I	28b. Time of Injury		yat k? Yes 2□N	lo 28f. Locati		urred nber or Rural Route Num	nber,	
To the Hoepital or within 24 hours after To the Funeral Dire completely filled in Medical Certi	29e. Certifier 1 Certifying Pl	nysician: To the best of my kn	owledge, deeth oc			d place, and due to				
n 24 n 24 pleter		miner: On the basis of examinand manner steted.							s)	
Within Comp	29b. Signeture end title of certifier			29c. Licens				ned (Month, Day, Year)		
	Tem Mile	no		200	040		03-0	2-99		
	30. Name and address of person who	completed cause of deeth (Ite	m 23a) (Type, Pri	int)						
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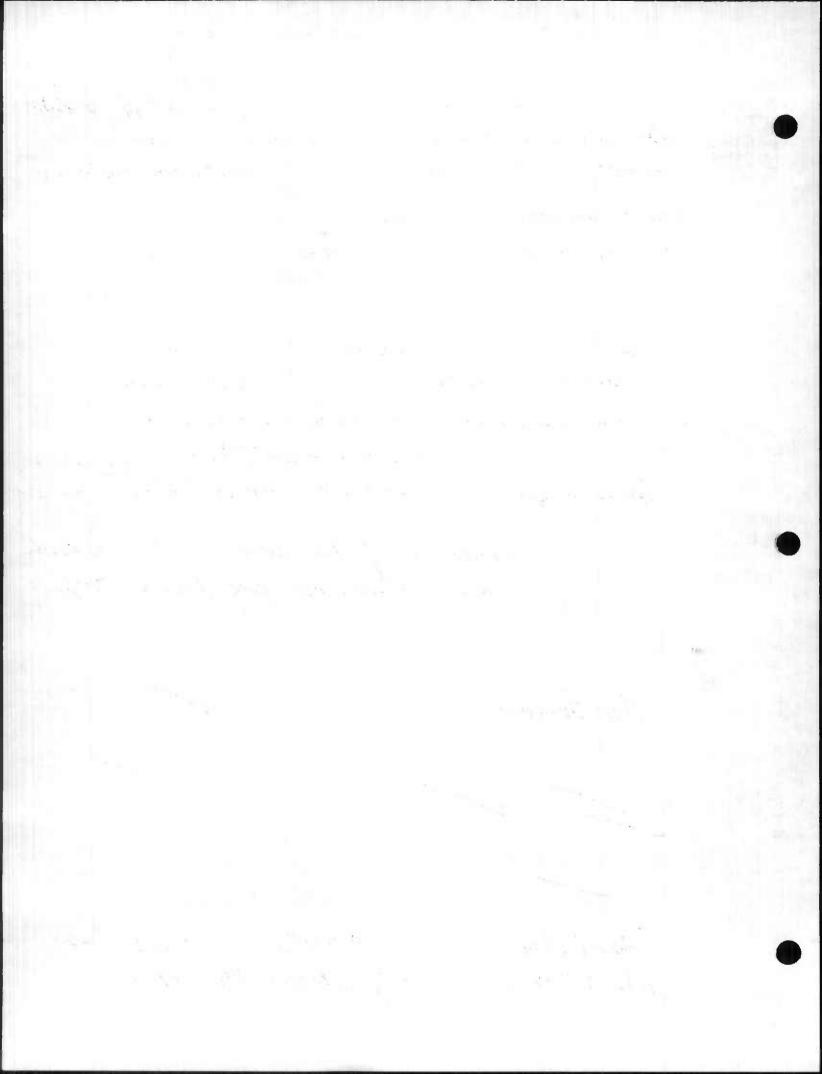


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Effie Belle BRECHBIEL 6:45AM e13 /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Hagerstown Washington 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 72 174-20-6953 Yrs Dec. Director 1926 Pennsylvania Usual Residence of Decedent filed within 72 hours efter deeth with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Director Washington Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 1105 Corbett Street Items 23a 21740 U.S.A. Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 21215-0020 6 1 Yes 2 No Specify: white 3 ☑ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 end 2 should be filed within 1ent of Health and Mental Hygiene. Int: If Item 27 is marked other than ' irry or other traumatic event, ma Ma Elementary/Secondery (0-12) College (1-4or 5+) 0-8 waitress restaurant Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Clarence Brechbiel Florence Rheam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5244 Daniel Dr., Bailey, N. C. 27807 Mrs. Edna M. Ramsey/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Locetion - City or Town, State Cedar Lawn Memorial Park 2,1999 1 Burial 2 □ Cremation 3 □ Removal from State Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 annes Tr. Selces 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760. attending physician Physician/Medicai Due to (or as a consequence of): P.O. been signed by the a should be deteched f Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobaccourse contributa to the causa of death? 10 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed has 1 Yes this certificate 2 540 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer deeth.

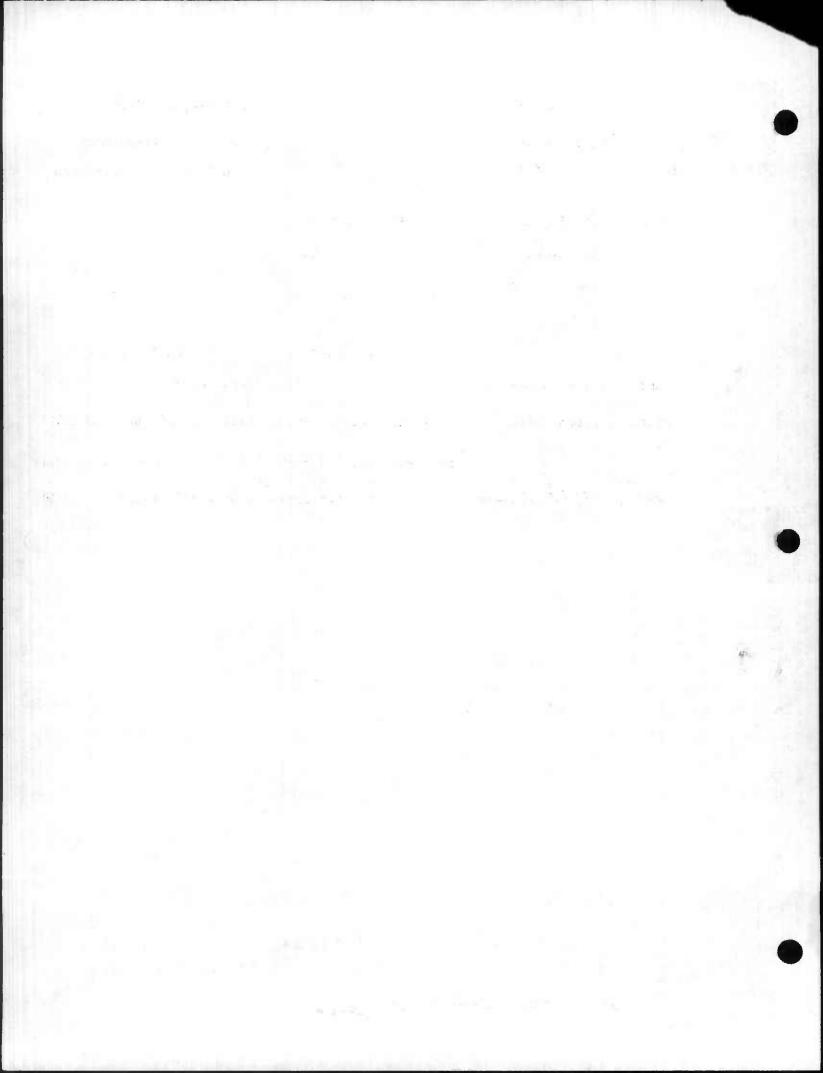
To the Funeral Director: After this certifica funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 3□ DOA 27. Manner of De 1 Matural 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. injury at Work? 28b. Time of 5 Pending Investigation 1 Yes 2 No 2 Accident completely filled in by the 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eted ceuse of deeth (Item 23a) (Type, Print) State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month February Harvey Lee Brown 9:05 am /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 12 East Sunset Avenue Williamsport Washington If Under 1 Year If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year) Feb. 12, 1925 Birthplece (State or Foreign Country)
 Mary land 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys Hours 1XXM 2□ F Yrs 74 Director 219-12-1449 Usuel Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1X Yes 2 No Director Maryland Washington Williamsport 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? deeth with 12 East Sunset Avenue USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 12. Yes 2 □ No If Yes, Give Yeer or Detes: 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 Specify: White 1 Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. i. Peges 1 end 2 should be filed wi tment of Health end Mental Hygien tant: If them 27 is marked other th jury or other traumatic event, the 10 Carpenter Self Employed Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles William Brown, Sr. Effie Pearl Pryor 19a. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Brown /Wife 12 East Sunset Avenue Williamsport, Maryland 21795 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremetion 3 Removel from State permit. Pege Depertment of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Greenlawn Memorial Park 3-3-99 Williamsport, Maryland 21. Signeture of Fugerel Service Licer Osborne Funeral Home 425 S. Conococheague St.Williamsport,MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or leart lailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician INFARCTION /Medical Immediete Ceuse (Finel Unknow. MYOCARDIAC disease or condition resulting in death) Examiner Due to (or es e consequence of)! HYPERTENSION The law requires that the death certificete be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760, the ettending physiclan Physician/Medical the Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? been signed by I should be detect 3 Probably 4 Unknown tenknown 1 Yes 2 No Records, þ Completed 24b. Were autopsy findings evelleble prior to 24a. Wes an autopsy performed? completion of cause of death? After this certificate has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital lai or Attending Physician: The ster death.
Is efter death.
In Director: After this certificated in by the funeral director, ps Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 DNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e 11 Certifying Phyelcien: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end manner es stated.
21 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end manner stated. Medical 29a. Certifier 29b. Signature and tilled certifier 29d. Date signed (Month, Day, Year) 29c. License number MO £4503 ulle 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) mo 217212 Pk MO. 19414-CLCGTERSBURG SHAHAB Z SIBBIOUT 31. Dete filed (Month, Day, Yeer) MAR 0 2 1999 32. Registrar's Signeture State

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First Middle Last) 2. Dete of Daeth Day 26 Month 1638 February COLIE DUNAWAY BRIMER 26 1999 4c. County of Death 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Months Deys Hours Min 1 M 2 XF 225-28-3905 7-12-18 Virginia Usuel Residence of Decedant 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Md. Worcester Snow Hill 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 301 Belt 21863 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grede complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b Kind of Business/Industry Elamantary/Secondary (0-12) Worcester Ctv Bd. College (1-4or 5+) Food Service 12 of Education 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Thomas Samuel Dunaway Eunice Sidnor (Dunaway) 19e. Informent's Neme/Reletionship (Type, Pnint) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) Roy Brimer (son) 209 McCallmont Rd., New Castle, Del. 19720 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Nelson Cemetery 3/3/99 Pocomoke, Md. 21. Signeture of Funerel Service Licenses 22. Name end Address of Facility P.O. Box 87 Dennis Funeral Home, Snow Hill, Md. 21863 alricia de Llennos 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Intarvel Between Onset end Death Immediata Cause (Finel disaase or condition rasulting in daath) DAYS GEREBRAL HEAMPHAGE Due to (or es e consequence of): PNEYMONIG DAYS Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Dua to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10e Stefe

Funeral

Director

r 28a-f show

7 is marked other than "natural", or itsms 23a or treumatic event, the Madical Examiner must be in

permit. Peges 1 and 2 should be filed within 72 hours efter of Department of Heelth and Mental Hygians. Important: If item 27 is marked other than "natural", or item any Injury or other treumatic event, the Medical Exercises page.

altimore, Maryland 21215-0020

Records, P.O. Box 68760,

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Certification:

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ò Hospital 24 hours Pert II. Other significent conditions contributing to deeth but not resulting in the undarlying cause given in Part i.

25. Wes case referred to medical examinar? 1 Yes 2. No

26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 TYes 2 No

5 Pending investigation Natural 2 Accident 6 Could not be 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one)

27. Menner of Deeth

Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner as stated.

2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and mannar stated.

29b. Signature end title of certifier Durgusy Woord 96

32014

29d. Date signed (Month, Day, Year)

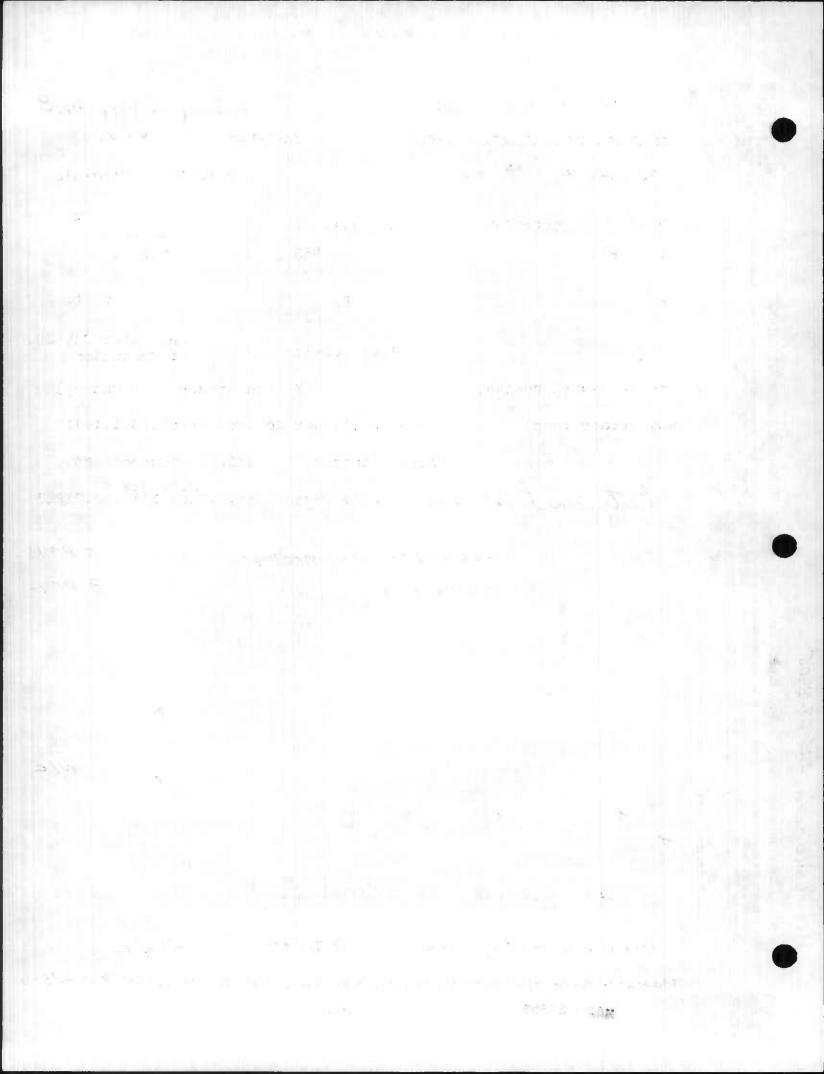
30. Name end address of person who complated causa of daath (Itam 23a) (Type, Print)

MD 106 MILENEDST SUN 504 B SGLABURY MD 2/804 MAMESH MOONDRA

State Registrar

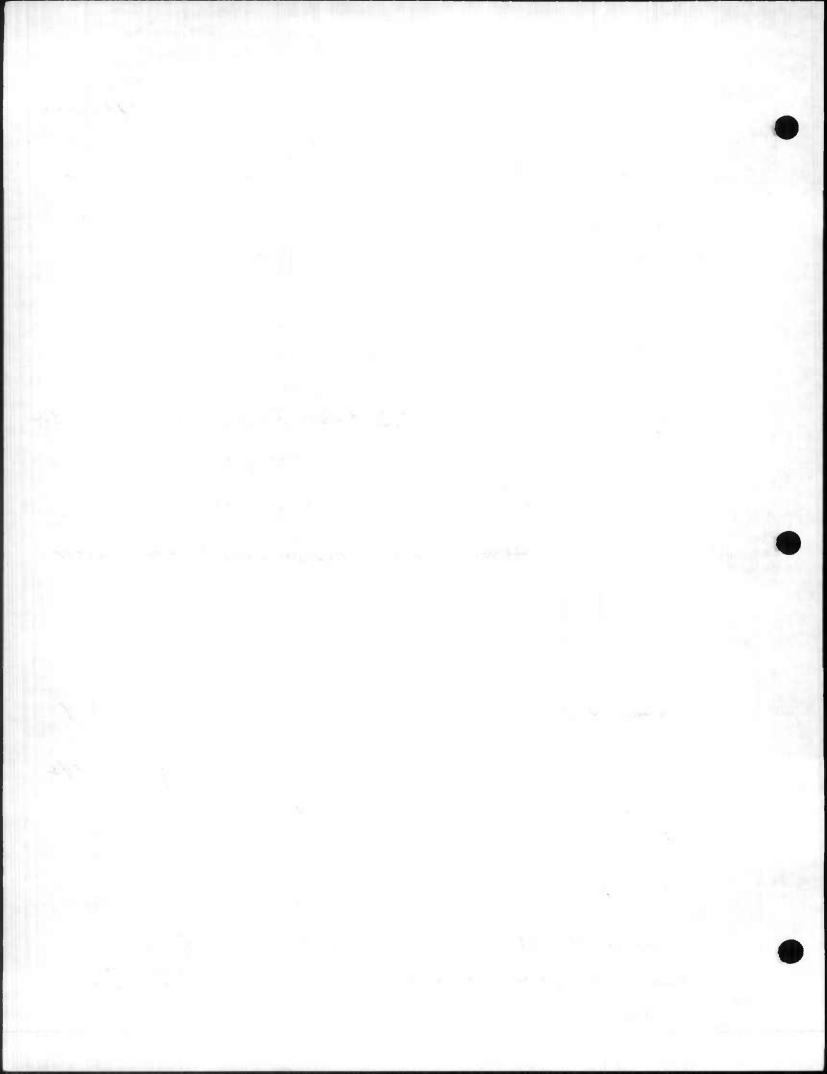
31. Dete filed (Month, Dey, Year) MAR 0 2 1993

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 9 08 0

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Funera Directo		5. Sociel Security Number 6. S 17 -09-8135 1 Usual Residence of Decedent	ex ☐ M X F 7. Age (Intyrs.	lest birthday) If Uni Month		der 24 Hrs. rs Min.	3 Mente of B	17906	9. Birthplace Country)	(State or Foreign
a Maryland a-f show	ctor	10e. State 10b. County WICO	mILO	ty, Town or Location $5i/i \le 6$	(we)					nside City Limits Yes 2 No
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d within 72 giona.	Completed	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	life, DO NOT	work done during n	nost of work	ing	16b. Kind of B	usiness/Industry	1
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E 10 Cd F		19a. Informent's Name/Relationship	Type, Pribl) 2419/17	19b. Mailing Addre	EVANS		al Route Num	per, City or Town,		21804
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permit. P Departme Importan any injur.		21. Signature of Funeral Service Licens	M00-4	17 22. Name	and Address of Fe	fun Md	ex2/	Home,	P.O. B.	× 61
Physician		23a. Pert1. Enter the disease, or companies shock, or heart failure. List only	olicefions thet ceused the deet one ceuse on each line.	th. Do not enter the m	node of dying, such	es cardiac	or respiretory	errest,	Inte	roximete rval Between ef end Death
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	L	Many Cuy 30. Name end eddress of person who of MAHESH MOON	completed ceuse of death (Item	n 23e) (Type, Print) 6 M/LF=0#	en st 50	11/1	50413	SKLI-13	YRY	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Hannah Mae Boone Feb. 26 1999 7:15 AM 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Long View Nursing Home Manchester Carroll If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys 1 ☐ M 2 🔀 F Months 100 Feb. 8, 1899 Maryland 220-28-4048 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☒ No Carroll Westminster 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 511 Sullivan Rd. 21157 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own_home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Ellsworth Nusbaum Gertrude Harman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 Hersh Ave., Westminster, MD 21157 Roger L. Boone - son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/1/99 nr. Linwood, MD Pipe Creek Cemetery 22. Name and Address of Facility 21. Signature of Funeral ServicesLicenses Hartzler Funeral Home 310 Church St., New Windsor, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final sed age disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

permit. Page Department of Important: If any injury or page.

Physician

/Medical

Examiner

10a. Stete

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Funeral

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death with the Maryland

Pages 1 end 2 should be filed within 72 hours aftar death with the Marylar ent of Health and Mental Hygiena.
Int: If item 27 is marked other than "natural; or items 23a or 28a-f ehow min: If item 27 is marked other than "natural; or other traumal to avent, the Madical Exempter must be notified any or other traumal to avent, the Madical Exempter must be notified as

Baltimore, Maryland 21215-0020

Examiner Physician/Medical 80 USB ò by Completed Be

2

Certification:

Wedicai

1 Yes 2 No

5 Pending

investigation

6 Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

The law requires that the death certificate be asscuted physicien end s the buriel-transit Division of Vital Records, P.O. Box 68760, been signed by the should be detached s certificate has t director, paga 2 s Attending Physician: funeral director. After this deeth. or Attendation of the deep n 24 hours after dee ne Funeral Director plately filled in by th

> State Registrar

completely

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2 Madical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certil

29c. License number

in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the ceuse(s) and menner as stated

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Dete of Injury (Month, Day Year)

John W. Middleton

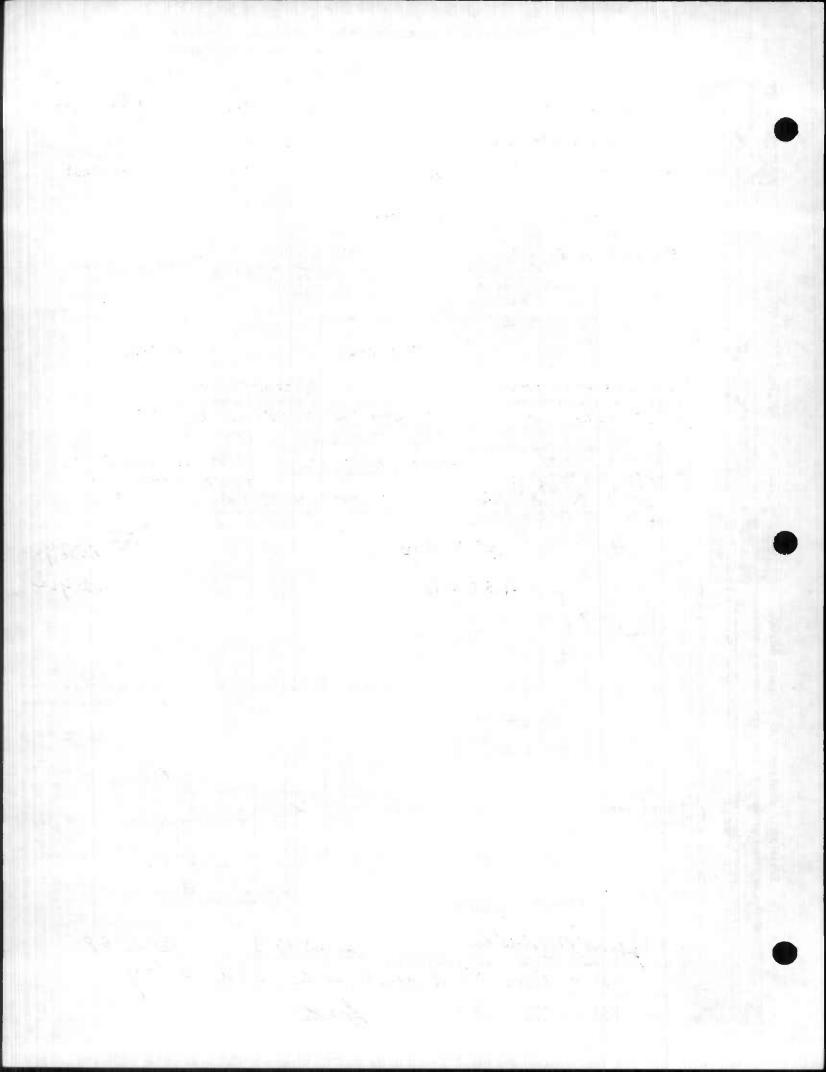
Westmuster Roa

2 ER/Outpatient 3 DOA

28b. Time of

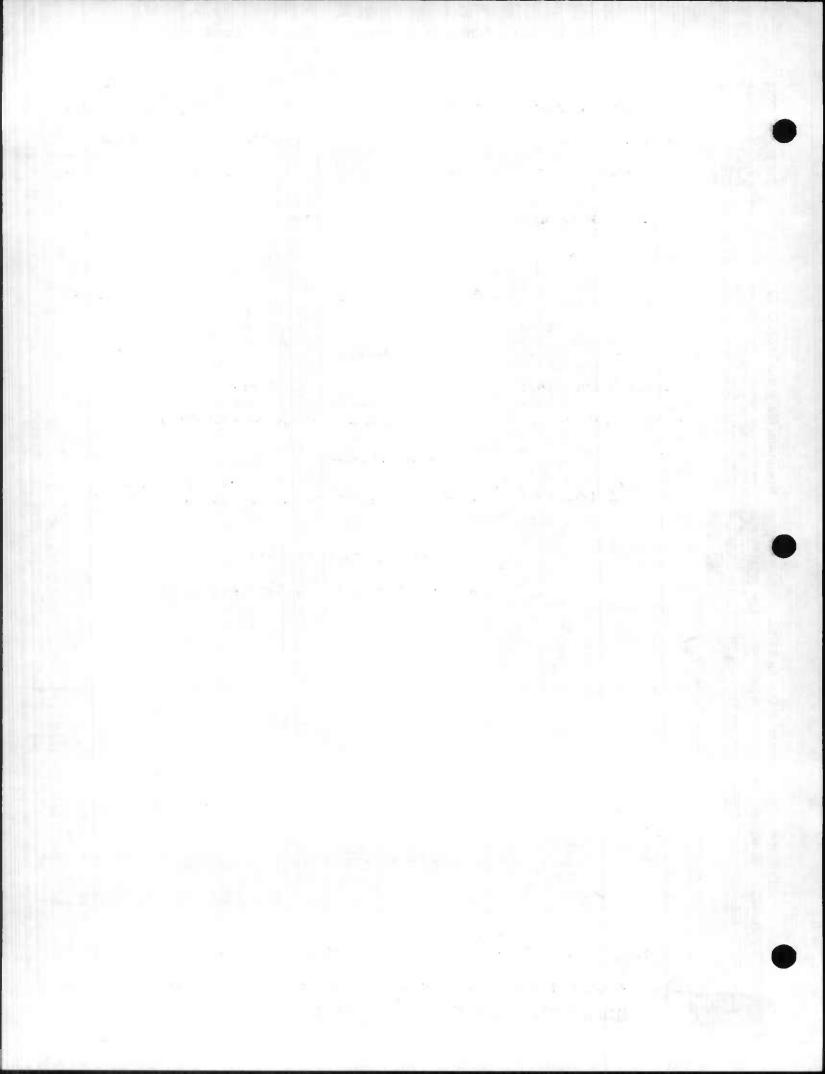
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 32. Registrer's Signature MAR 0 2 1999



State of Maryland / Department of Health and Mental Hygiene 9 9 08 103

			ertificate of Death	Reg. No.	00100
		1. Decedent'a Name (First, Middle, Last)		2. Dete of Deeth	3. Time of Death
	Physician	Emerson Edward Barnes		Feb 27, 199	9 2:00 am
M	/Medical Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Lo		
4		5310 Emory Road	Upperco	o Balf	timore
ľ	Funeral Director	5. Social Security Number 212-09-4612 6. Sex 1 M 2□ F 7. Age (In yrs. last birthda 85 Yrs.	Months Devs Hours Min.	6. Date of Birth (Month, Day, Year) Jan 13,1914	9. Birthplace (State or Foreign Country) Maryland
	pu &	Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	short short				1 ☐ Yes 2€ No
	28s-1	Maryland Baltimore 10e. Street end Number	Upperco	10g. Citizen of V	
	23a or 2	5310 Emory Road	21155	U	SA
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Meryland Department of Health and Mental hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Naver Merried 2 Married 1 Naver Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Spe If Yas, specify Cuban, Mexican, Puerto Yas 2 No Specify: 	ecify Yes or No- Rican, atc.) 14. Rac Biec Specify	e - American Indian, ck, White, etc. White
5-0	72 h natu dical	15. Decedent's Education 16e. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation iva kind of work done during most of worki a. DO NOT use retired)	ing 16b. Kind of Bu	usiness/Industry
21	nan "	Elementary/Secondery (0-12) College (1-4or 5+)			nking
2	Sor the Cor	10	Banker		
ng	d out Hear Hear Hear Hear Hear Hear Hear Hear	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Sumam	10)
N N	Ment Ment Ment Ment Ment Ment Ment Ment		Nona P		
Maryland	2 sh and is m		ailing Address (Street and Number or Rure		State, Zip Code)
	fealth m 27 her t		10 Emory Rd, Upperco		City or Town, State
Baltimore,	Pages 1 ment of H ant: If ite ury or ot	1 Buriai 2 □ Cremation 3 □ Removal from State cemetery, c	crematory or other place)		co, MD
Balt	Departimbers any injusting	21. Signature of Funeral Service Licensee, Licensee, Clare	22. Name and Address of Facility E 934 South Main S	line Funeral Hot, Hampstead, 1	
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Right Cerebro: Due to (or as a condition or should be condition)	vusquar Accident sequence of: ascular Disequ	it se	Onset and Death
x 68760,	death certificate be executed e attending physician and of or use as the bunat-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consist of the	sequence of):		
Box	attendin for use				
P.O.		Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part I.	23b. Did tobacco use co	ntribute to the cause of death? 3 Probably 4 Unknown
Records,	aw requires been size should			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
R	The law eta hes to paga 2 s			1 ☐ Yes 2 🗹 No	1 ☐ Yes 2 ☐ No
Vital	ysician: The is certificate director, pag	25. Was case referred to medical examiner?	26. Place of Deet	h (Check only one)	
of V	Z 0 0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpet	tient 3□ DOA Other: 4□ Nursing Ho	ome 5 Residence 6 Oth	ner (Specify)
Division o	After fune	27. Manney of Deeth 1 Natural 5 Pending (Month, Dey Year) 2 Accident investigation		28d. Describe how injury occur	red
Divis	tal or Attanding P in setter death. The forestor: After the following the funeral Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, efc. (Specify)	street, factory, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
	To the Hospital or Attandwithin 24 hours effar daali virtue Funeral Director: complately filled in by the Medical Certifical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or end manner stated.	eath occurred at the time, date and place, Investigation, in my opinion, deeth occurr	and due to the ceuse(s) and me red at the time, dete end place,	enner as steled. and due to the cause(s)
	Withir Comp	29b. Signature and title of certifier	29c. Licansa number	29d. Date signe	d (Month, Day, Year)
		M. M. II. M. M.	JONK195	24 3-0	1-99
		30. Name and address of person who completed cause of death (Item 23a) (Typ	pe, Print)		*
		Dr. Hettert Herderson 295		restminites	MD 21157
	State	31. Date filed (Month, Day, Year) 32. Registrer's Signature	. Sparks	2 114 11 30 10	
	Registrar	MAR 0 2 1999	· japours		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Bowen 0.30am hillp 4a. Facility Nema (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Copper Ridge Sykesuille Carroll If Undar 1 Yaar Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) 12 M 2□ F 217-16-7230 78 une 5, 1920 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No y Keg ville arrol 10e. Street and Number 10g. Citizen of What Country? 21784 USA 710 Obrech1 Load . Was Decedent Ever in U,S. Armed Forces? 1 Layes 2 □ No If Yes, Give Year or Dates: ,942 '43 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indien, Bleck, Whita, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Commercial Credit-loans Supervisor 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bowen Vosephus Wilson Weisman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) 1497 Lara Rd, Mary Jane Bowen, wife 20a. Method of Disposition VA. Lancaster 22503 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Buriai 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cenetery 3. 2.99 Garrison, 22. Name and Address of Facility Pritts Funeral Home & Chapel, P. A. 412 Washington Rd. Westminster, MD. 21157 21. Signature of Funerel Service Licensee Westminster, M. Enter the disease, or compilections that caused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, or haart failura. List only one cause on each line. Approximate Immediate Ceuse (Final disease or condition rasulting in deeth) YEARS Dua to (or as a consequence of): Due to (or es e consequence of): Due to (or es a consaquence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed?

Physician /Medical Examiner

The lew requires that the death certificate be executed

this certificate

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

ŏ

"naturel", or Items 23a

permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mantal Hygiena. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercised once.

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

traumetic event, the Medical Examiner must be notified at

Physician/Medical Examiner physician end the burief-transit Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director, t Be

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Ceuse (Diseasa or Injury thet Initieted avents resulting in daath) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 No 1 ☐ Yes 2 🔀 No 25. Was cese referred to medical exeminer?
1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4₺ Nursing Home 5 ☐ Residance 8 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Daath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding invastigation 1 Naturel 1 TYes 2 TNo 2 Accidant 6 Could not ba 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida TX Certifying Physician: To the best of my knowladga, daath occurred at the time, deta and place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the causa(s) end manner stated. Medical 29a. Cartifiar

State Registrar

31. Dete filed (Month, Day, Year)

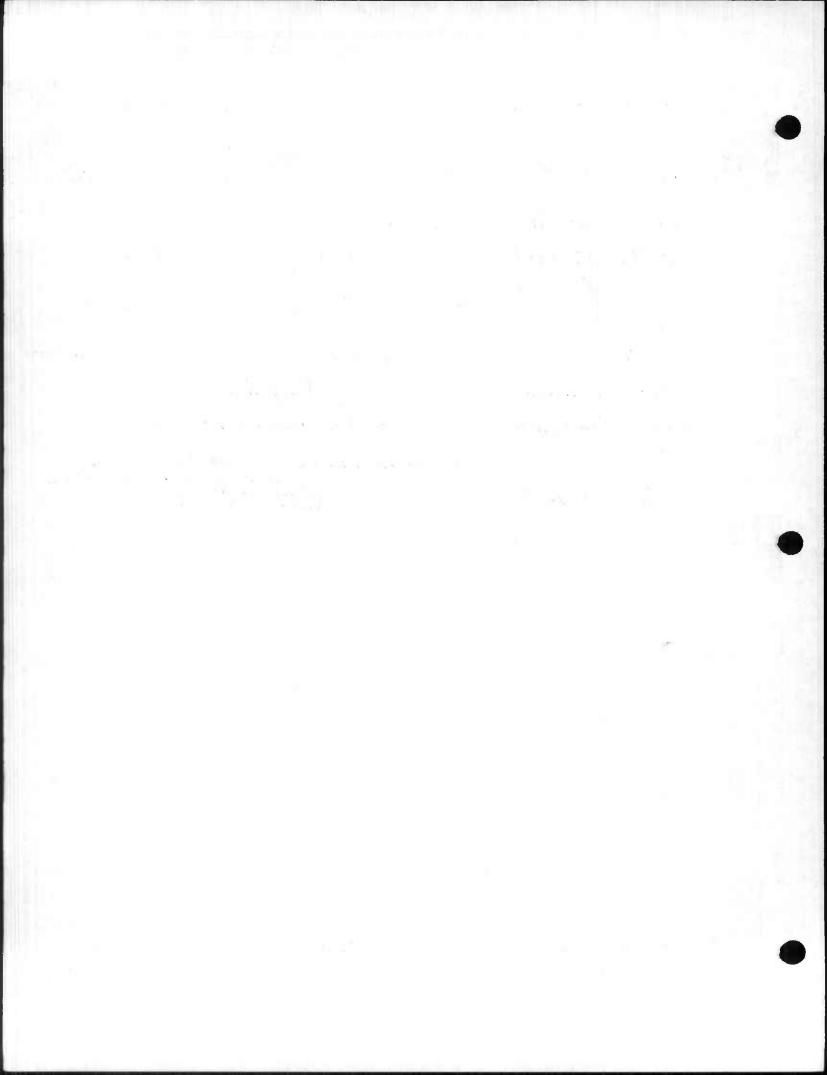
29b. Signeture and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Itam 23a) (Type, Print) ERNESTINE WRIGHT, COPPER RIDGE, 710 ORRECHT ROAD, SYKES VILLE, MD 21784

29c. License number

29d. Deta signed (Month, Day, Year)



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlat, cremation, or removal.

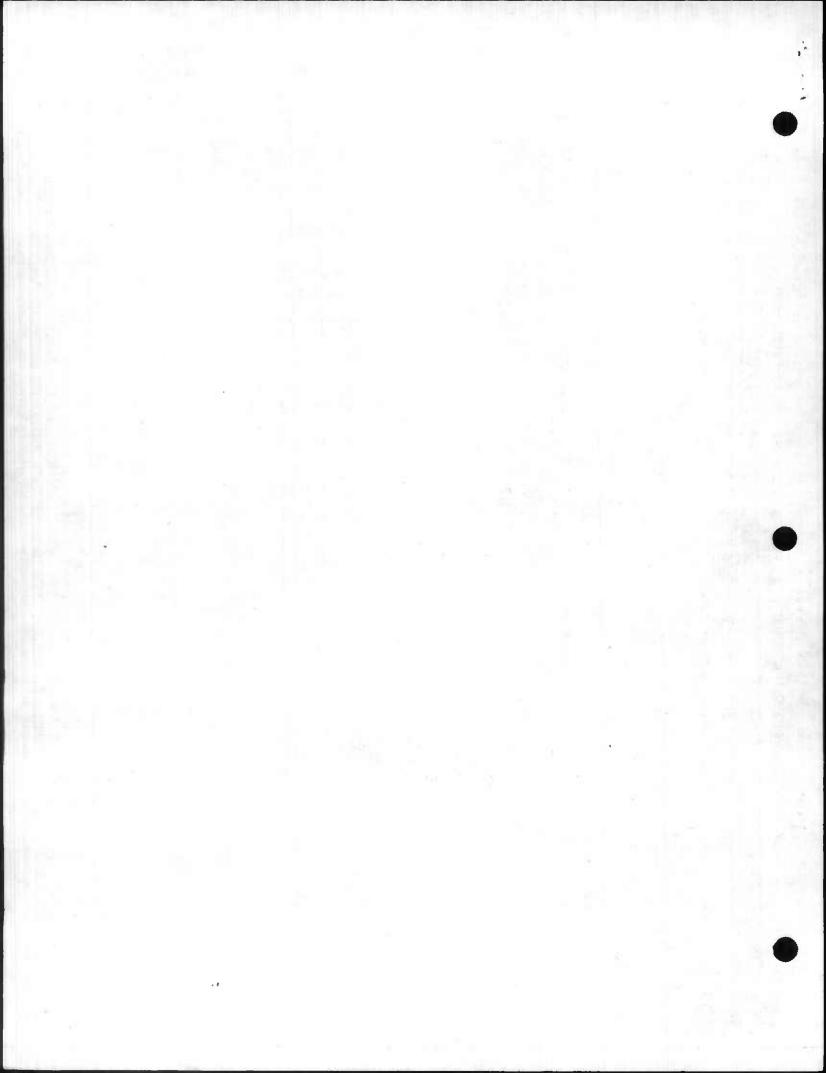
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL	HYGIENI REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) Betty Elaine CL					MONTH	OF DEATH		EAR	TIME OF DEAT	P.,
	4. SOCIAL SECURITY NUMBER	T	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE (OF BIRTN	90		ACE (State or For	nian
	219-20-0587	1 □ M 2 💢 F		MONTHS DAYS	HOURS MIN.	Feb.	, Day, Year)	926 1	Mary	land	ong//
5	90. FACILITY NAME (If not institution, give to 100 E. Wilson Bo				OR LOCATION OF DI L'S LOWN	EATN		9c. COUNTY		n hingtor	n
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT										
DIRECTOR	Maryland Washi			town or Local erstown	TION					d. INSIDE CITY LIMITS? YES 2 []	NO
LOWERAL	100 E. Wilson	Boulevard		10	1. ZIP CODE 2174()		10g. CITIZEN		T COUNTRY?	
DI LOM	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR O	2 XNO	If yes, ap	CENOENT OF NISPAI ecify Cuban, Mexica 2 2 NO Specifi	in, Puerto F			RACE	American India	n,
	15. DECEDENT'S EDU		16e. DECEDENT'S	USUAL OCCUPATI	ON	16b.	KIND OF BUS	INESS/INOUS		white	
COMPLEIED	(Specify only highest grade Elementery/Secondery (0-12)	College (1-4 or 5+)	(Give kind of w life. Do NOT us	ork done during me	ast of working						
L L	11	0	clerk					super	mark	et	
	17. FATHER'S NAME (First, Middle, Last) John Franklin Gre	ove. Sr.			16. MOTHER'S NA		diddle Maiden : ite Ne		r		
4	19e. INFORMANT'S NAME (Type/Print)	370, 521	19h MAILING	ADDRESS (Street	and Number or Rural			_			
2	Ward J. Clem - so	on			d Ave., I					0	
	20e. METHOD OF DISPOSITION 1 Burisl 2 S Cremetion 3 Ren	noval trom State	b. PLACE AND DATEO	F DISPOSITION (N	ame of	OATI		CATION — CIT			
	4 Donetion 6 Other (Specify)		Hagersto			3-2-	.99	Hager	stow	n,Md.	
	21. SIGNATURE OF ALMERAL SERVICE LI	Mumu	de		E. Wilso		MINNIC				L740
N/	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	aDUE TO (OR AS	A CONSEQUENCE OF	Cancer):						Approxima interval Be Onset and	Death
CENTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	A CONSEQUENCE OF								
MEDICAL	PART II. Other significant condition	ns contributing to death	but not resulting i	n the underlyin	g cause given in	Part I.	24a. WAS AN PERFOR	MED?	CO	ERE AUTOPSY FIRMILABLE PRIOR OMPLETION OF C	TO AUSE
	DID TOBACCO USE CONT	TRIBUTE TO CAUSE (OF DEATH YE	S NO	UNCERTAI	N 🗆					
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only one							
2	1 YES 2 NO 27. MANNER OF OEATH	t Inpatient 2 ER/Ou		4 - Nursing Hor	ne 5 PResidence						
	t Neturel 5 Pending	25e. OATE OF INJURY (Month, Day, Year)		URY	JURY AT ORK? YES 2 NO	28d. OES	CRIBE HOW II	JURY OCCUI	REO		
IED DI	2 Accident 3 Suicide 6 Could not be determined 4 Homicide Could not be determined 269. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route No. City or Town, State)						te Number,				
COMPLE	ama)	SICIAN: To the best of my kno								nd manner ea st	Inted.
DE C	296. SIGNATURE AND TITLE OF CERTIFIE	ER .			29c. LICENSE NU	MBER		29d. DATE S	IGNED (M	fonth, Day, Year)	
	muchael q.	Melanul	MO		0416	67)	3.2	. 99	
	30. NAME AND ADDRESS OF PERSON W M('chall T. M 31. OATE FILEO (Month, Day, Year) MAR 0 4		1110 Mes	/ .	myers	RI	Suik	130	1/2 sc	spown !	MO.

of.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 5, per F.D. 3/2/99, Carroll County, wjl Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Fabruary **Physician** 1:45 mm 1999 VICTOR W. CAUDILL /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Witsminster Carroll 14877 County Carrell If Under t Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 1√2 M 2□ F 14 4236 Director 86 JULY 26,1912 SPARTA, NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1☐ Yes 2☐No Director MD CARROLL MANCHESTER 28a-1 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? ò 21102 238 U.S.A. 3332 MAIN STREET Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, t2. Wes Decedent Ever in U,S. Armed Forcas? Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give Year or Dates: 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) YAZOO MILLS 8 LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental MACK D. CAUDILL ELLEN KROUSE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) * nt of Health a : If Item 27 is : or other trai NANCY L. CREASON/GUARDIAN 465 CLEARVIEW RD., HANOVER, PA 17331 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Buriel 2 Cremation 3 Nemovel from State 2/25/99 GLENVILLE, PA 4 ☐ Donation 5 ☐ Othar (Specify) St. JACOB'S Church 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility ELINE FUNERAL HOME 934 S. MAIN ST. , HAMPSTEAD, MD 21074 23a. Partt. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heer failure. List only one causa on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final one week disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to Immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Ono 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 0 15 Attending Physician: 25. Was case referred to medical 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Rasidenca 6 ☐ Other (Specify) 1 Yes 2N No Division of 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Satural 2 Accident 5 Pending 1 Yas 2 No death. investigation 24 hours after deat Funeral Director: 6 Could not be datamined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 6 Hospital 1x Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and fittle of certific D48006 1999 Memorial Ave Westminster, mi) 21157 30. Name and address of person who compléted cause of death (Item 23a) (Type, Print) 200 130 EY 3t. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 1999 Evelyn Ruth Conner 22 Lebruary /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Union Hospital Elkton Cecil 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Worth, Pay Year 1/27/1918 Birthplace (State or Foreign Country) 6 Sex **Funeral** Hours 1 ☐ M 2 🕱 F Months Deys 161-18-3862 81 Pa. Director Usual Residence of Decedent the Marylend 10e Stete 10c City Town or Location 10b. County 10d. Inside Cltv Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Medical Examiner must be notified at 1 ☐ Yes 22 No Delaware Director Sussex Bethany Beach 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code With 34 Alabama Drive 19930 USA Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer c. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic svent, the Medical Evantage. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White altimore, Maryland 21215-0020 Specify: P 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) assistant store manager retail sales 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Louis I. Yohn Vema Ginghery 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Christine Phillips 25 Barksdale Court, Elkton, Md. 21921 20a. Method of Disposition

Buriel 2 □ Cremetion 3 □ Removel from State 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete cemetery, crematory or other plece) St. Georges Cemetery 2/25/99 Clarksville, Delaware 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Watson Funeral Home, Inc., Millsboro, De 19966 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediete Ceuse (Final Septie Stock HOURS diseese or condition resulting in deeth) Examiner Examiner Peripheral Vascular Disease law requires that the death certificete be executed ettending physicien end for use as the burial-tren Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest CORONARY Disenia Artery P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Wes en autopsy performed? 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed peed certificate hes 1 ☐ Yes 2 ☐ No 1 □ Yes 2 1000 Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of 1 Naturei 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) end manner steted. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number February 23, 1999 MO DO0 47711 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) North East Maryland

3 Mandis Avenue

32. Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar David

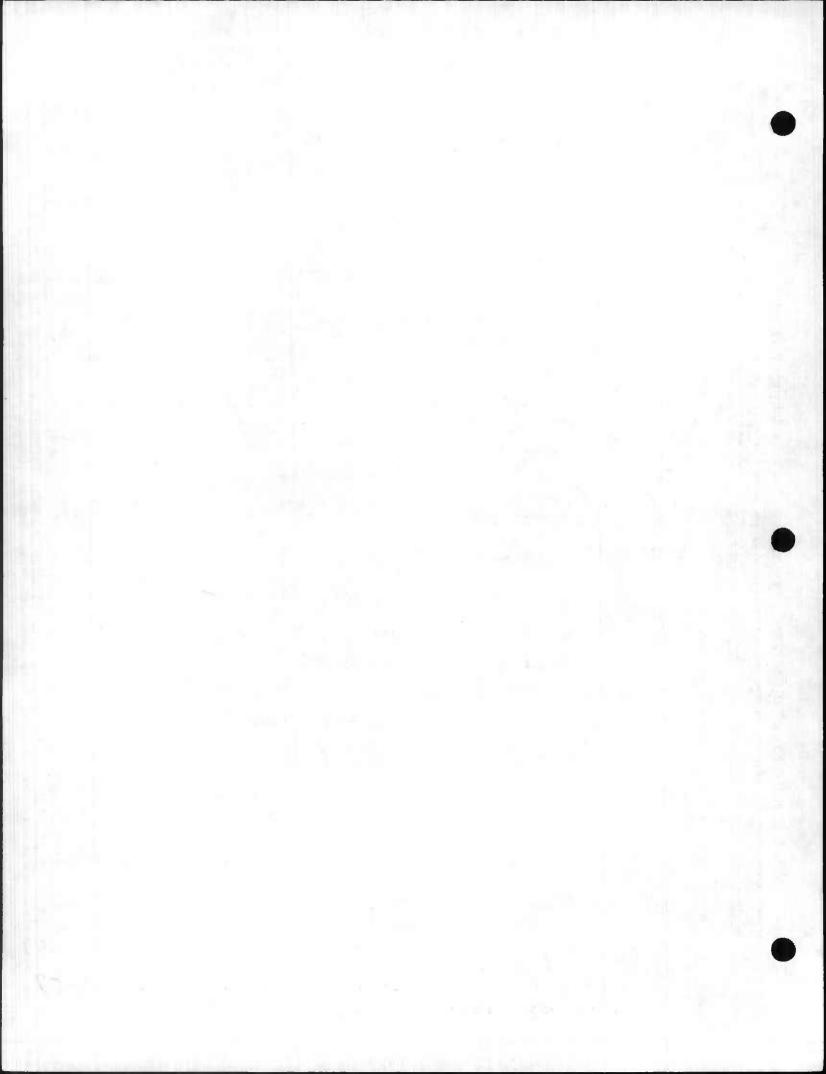
Gar-El

31. Dete filed (Month, Dey, Year)
MAR 0 3 1999

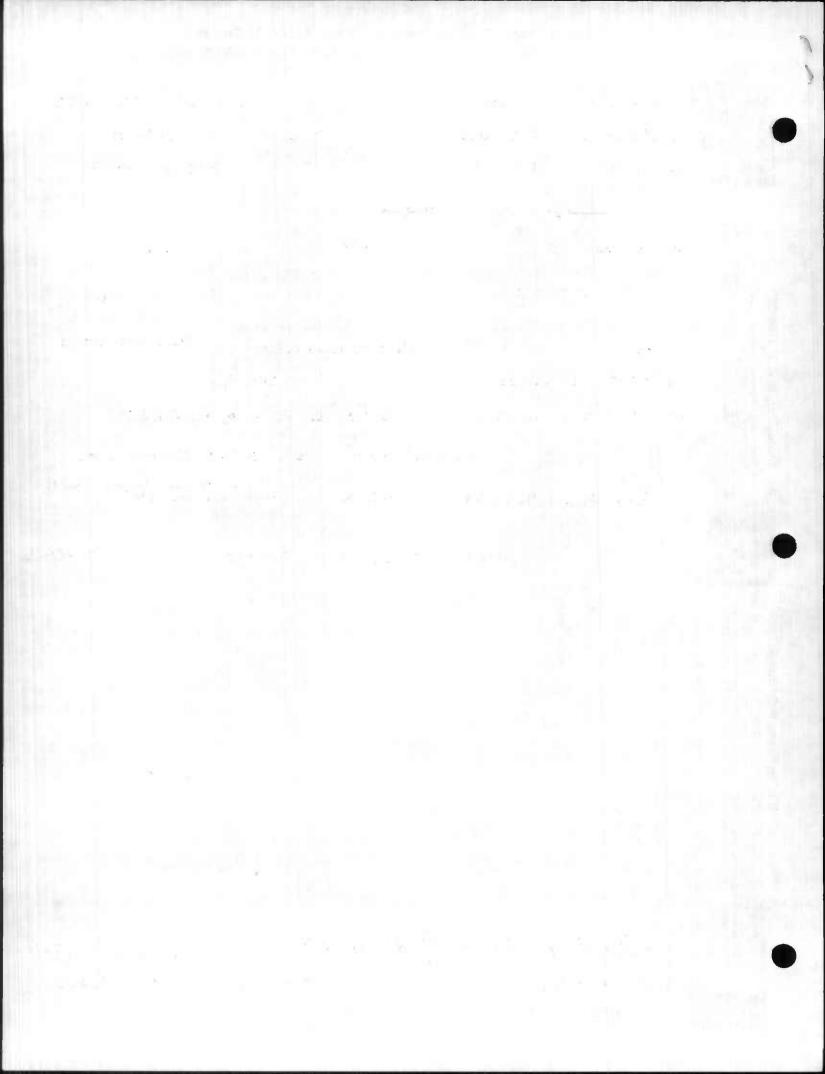
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State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death Reg. No. 99 08 108
Physician	1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Day Year 3. Time of Death
/Medical	Robert Frey February 28 1999 1207 AM
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death
**	JONNS HOPKINS HUSPI to DOITIMER BAITIMORE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth 9. Birtholace (State or Foreign)
Funeral Director	5. Social Security Number 182-40-5798 6. Sex 110 M 2 F 7. Age (In yrs. last birthday) 182 F 7. Age (In yrs. last birthday) 182 F 7. Age (In yrs. last birthday) 183 F 184 F 185 F 1
show a show	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit:
Men Heat Tor	PA Franklin Chambersburg 1□Yas 2次No
ter deeth with the Meryle teams 28s or 28e-1 show instrument be notified as "unersal Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1587 Newcomer Road 17201 US
by I	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give 1 Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 14. Race - American Indian, Black, Whita, etc. 14. Race - American Indian, Black, Whita, etc. 1 Yes 2 No Specify: 1 Yes, Give Year or Dates: 1 Yas 2 No Specify: White
the structure of the st	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed 16b. Kind of Businass/Industry 16b. Kind of Businass/Industry 16b. Kind of Businass/Industry 16b. Kind of Businass/Industry 16c. Do NOT use retired) Dairy Farming
3 515 -	17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama)
Mentel Hyginal Mentel Hyginal	Adin L. Frey Janet Martin
d 2 should be the and Mental of Temarked of treumatic events of To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)
- 6945	MRs. Dorothy Frey Wife 1587 Newcomer Road Chambersburg, PA 17201
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	20a. Method of Disposition 20b. Place of Disposition (Nema of cermetory or other place) 20c. Location - City or Town, State
Destrict Department Important: Peg eny Injury o	21. Signature of Funeral Service Licensee 22. Nama and Address of Facility
Departiment in port	Thomas L. Geisel Funeral Home, Inc.
	333 Falling Spring Road Chambersburg, PA 17201 234 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Locatic Ac. Ac. Ac. Ac. Ac. Ac. Ac. Ac. Ac. Ac
	Due to (or as a consequence of):
p = E	b. Liver Failure ilday
ficete be executed to physician and is the burishtraneit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): 450ay5
flicate be ex g physicien se the burlel	Cause (Disease or injury that initiated events
	To 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
the death cert y the estendin sched for use ysician/M	a Dittuse Large Cell Lymphoma ildmonth
e d to	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death
- F 65 6	Renal Failure, Graft Versus Host Discuse 10 Yes 2 No 3 Probably 4 Unknow
been should	24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
	1X Yas 2□No 1□Yas 2X No
certificate inector, peg	25. Was case referred to medical 26. Place of Death (Check only one)
- K - 5 C	examiner? 1 Yes 2 X No
To the Hospital or Attending Physician Within 24 hours efter deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) M 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)
he Hospital in 24 hours he Funeral D pletely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
within 2 To the comple	and manner stated. 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year)
or or a	
	Julia Brahmer, MD DOD 51770 February 28 1999. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julia R.Brahmer, MD Johns Hopkins Hospital Baltimore, MD 21287
State Registrar	31. Date filed (Month, Day, Year) MAR 0 1 1999 32. Registrar's Signatura 4. Society



hysician /Medical			(First, Middle, Last) William	Farwell		7117001		Death	2. Date of De Month Feb	Reg. No eath 25 Da		999	3. Time of Death 7:08am
xaminer	4a	Facility Name (#F	not Institution, giva k Memoria	street and number) l Hospital				4b. City, Town, or Le Frederick			county ceder		
neral ector	C	Social Security Nu 04-22-10	56 15	7. Aga (In yrs 72 72	last birthday Yrs.) If Unde Months	r 1 Year Deys	If Undar 24 Hrs. Hours Min.	8. Date of Bid Month, Da July 1	th Year	26	9. Birthple Count Maine	aca (Stata or Foreigny)
nothed at		sual Residenca of I e. State Md	10b. County		ty, Town or L		Walk	ersville				10	d. Inside City Limits
free must be notified Funeral Director	10	e. Street and Num 06 Brack	en Court				793			-	tizen of V JSA	Vhat Count	ry?
à À		. Marital Status 1 Never Marrie 3 Widowed 4	d 2 Married	12. Was Decedent Ever in the Armed Forcas? NETYes 2 No 19 KYes, Give Year or Datas: 19		Was Dece If Yes, spe 1 Yes	cify Cub	lispanlc Origin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No Rican, etc.)	>	Blac	a - America k, White, e	tc.
Completed		(Specif	15. Decedent's Educ y only highest grade	cation a completed)	(Giv	edent's Usu	ork done	during most of work	ing	16b. l	(Ind of Bu	usiness/Ind	ustry
idmo		Elementery/Secon	dary (0-12)	College (1-4or 5+)		inist:		we office:	r	U.S	S. Ag	gricul	Lture
To Be C	11/	. Fathar's Nama (F Robert W.	First, Middle, Last) illiam Fa	rwell				18. Mother's Nam Ruth Eth		, Maide	n Sumem	ie)	
To Be Comp	15 M	e. Informant's Nar Irs. Ann	me/Relationship (Ty) Farwell	pe, Print) (spouse)				and Number or Run					Code)
	20		osition Cremation 3 R Dother (Specify)	americal from Chate	Placa of Disponentary, cra Croll (amatory or	other pla	Serv. 2	Data -26-99			City or Tove	
eny injury	2	I. Signature of Fun	eral Service Licanse	00	1			ss of Facility Ha	ight Fu	nera	al Ho	ome &	Chapel
	2	3a. Part1. Enter the	Hought	cations that caused the dea ne cause on each line.				195 Sykes'			21/8	34	Approximate
ian		shock, or heart	feilure. List only on	ne cause on each line.									Interval Between Onset and Death
ical iner	di	nmediate Cause (F sease or condition suiting in death)	inal a	METASTA Due to (TIC or es e conse			e CAN	cer		-	1	9 years
bunal-transit	Sil	equentially list con- any, leading to im- suse. Enter Under	ditions, mediate	Due to (or es a conse	equence of)	:				7	İ	
for usa as tha bu	th	ause (Disease or Ir at initiated events suiting in death) La	njury	Dua to (or as a conse	quenca of):							
d for us	Ps	et il Other algorific	eant conditions con	tributing to death but not re-	sulting In the	underlylna	nausa ni	ven in Part I	23h Did	tobacc	O USB COI	ntributa to	the cause of death
che che											2 13 No		ably 4 ☐ Unknov
e data									24a. Was	an auto ormed?	opsy	ava	re eutopsy findings illebla prior to appletion of cause leath?
nas been sylved by the attaining prystal 2 should be datached for usa as tha npieted by Physician/Medic	-										2 No	1 🗆	Yes 22 No
or, page 2 should be dated	26	Was sara rafarra	ad to medical					26 Place of Deel	th (Check only	one)		or (Specific	
To be Completed by Physician/Medic	25	. Wes case referre examiner? 1 □ Yes 2 ☑ N	-	lospital: 1 ☐ Inpatient 2 ⊡	ER/Outpetie	ent 3 D	OA Ott		ome 5 Res	Idenca	6 Oth	al (Sharill)
the funaral director, page 2 should be date cation: To Be Completed by Ph		examiner? 1 Yes 2 N Manner of Deeth 1 Neturel 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time Injury	of M	28c. Inju Wo 1	ner: 4 Nursing Ho	28d. Describe	how inj	ary occur	red	
Certification: To Be Completed by Ph		examiner? 1 Yes 2 N Manner of Deeth 1 Neturel	5 Pending	1 Linpatient 26	28b. Time Injury	of M	28c. Inju Wo 1	ner: 4 Nursing Hory at rk?	28d. Describe	how inju	nd Numb	red) Route Number,
ately filled in by the funaral director, page 2 should be date director. To Be Completed by Ph	27	examiner? 1 Yes 22 N Manney Deeth 1 Neturel 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Dey Year)	28b. Time Injury	of M treet, factor	28c. Injui Wo 1	Nursing Hory at K? Yes 2 No	28f. Location City or To	Street a	nd Numb	per or Rure	Route Number,
- D	27	examiner? 1 Yes 2 ON Manney 2	5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Dey Year) 28a. Place of Injury - At houlding, etc. (Specialcian: To the best of my kniar: On the basis of examinar.	28b. Time Injury	M treet, factor th occurred nvestigation	28c. Injury Wo 1	Nursing Hory at K? Yes 2 No	28f. Location (City or To	Street awn, Star cause(s	nd Numb e) s) and ma	per or Rure	Route Number, ated. the cause(s)
Complately filled in by the funeral director, page 2 should be date. Medical Certification: To Be Completed by Ph	29	examiner? 1 Yes 2 Deth Manner Deeth 1 Neturel 2 Accident 3 Suicide 4 Homlcide Da. Certifier (Check only one)	5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Dey Year) 28e. Place of Injury - At he building, etc. (Specialcian: To the best of my kniar: On the basis of examinating and manner stated.	28b. Time Injury	th occurred hivestigation	28c. Injury Wo 1	ner: 4 Nursing Ho	28f. Location (City or To	Street awn, Star cause(s	nd Numb e) s) and ma	per or Rure anner as stand due to	Route Number, ated. the cause(s)



	ITEM: #8	PER	F.H. G770 4-14-99 WR		Maryland		rtment of tificate of				giene 19 9	0.8	110
			1. Decedant's Nama (First, Middle, L	ast)					1	2. Data of Dea			3. Tima of Death
	Physici /Medi	al	BRIANA PAIG		GOSSARD			4b Ciby To		Month ebruar ation of Deeth	,	1999	8:37 PM
	Examir	ier	THE RESERVE AND A SECOND SECON								4c. County		
-			Washington Count 5. Social Security Number 6.	-		n me formeto min	If Undar 1 Year	Hager	S L OWI	Date of Bird	wasn:	ington	
	Funeral Director		219-08-9855	1□ M 2⊠ F	7. Aga (In yrs. k	15 Yrs.	Months Deys		Min.	B. Data of Birth (Month, Day	Year) 1983	Gountry, Mar	y land
	and *		Usual Rasidance of Decedent 10a. Stata 10b. County		10c, City	. Town or Loc	cation					10d	. inaide City Limits
	Aarylar F show	ō	Manufand Manh	+		ш							1 ☐ Yaa 2 ◯ No
	the h	Director	Maryland Wash	ington		П	agerstow 10f. Zip Coda	n			IOg. Citizen of \	Affroi Country	
	ath with the Maryla 23a or 28a-f show			.1			217	12					
	eath	era	119 Dartmouth Dr	-,	dant Evar in U,S	C 12 W			ain? (Casa	ih. Van ar Na		USA e - American	Indian
120	be filed within 72 hours efter death with the Maryland lel Hyglene. I dither than "naturel", or items 23a or 28a-f show event, the Medical Exeminer must be neutral at	by Funeral	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Yas If Yes, Give Yaar or Da	ces? 2)() No a		Ves Decedant of Yes, specify Cut		n, Puarto Ri	ican, atc.)	Blac	ck, Whita, atc	
8	"naturel",		15. Decedant'e E			18a Deced	ant's Usuel Occu	netion			16b. Kind of B		
5	be filed within 72 hatel Hyglene. d other than "natuevent, the Medical	Completed	(Specify only highast g	rada complated)		(Giva I	kind of work done	during most	t of working	7	TOD. KING OF B	usiriass/irious	tiy
212	within then	E C	Elementery/Secondery (0-12)	Collaga (1-	-4or 5+)		Student	,			Edu	cation	
P	Hyg Hyg	Ö	17. Fether's Name (First, Middla, Las	it)			OTUGENT	T	ar's Nama (First, Middla,	Maidan Suman		
Maryland 21215-0020	nd 2 should be filled within sith and Mantel Hyglene. 27 is marked other than traumatic event, in a least traumati	To Be	Theodore Willia	am Gossa	ard			Tina	a Ma	rie L	itten		
2	shou mar	-	19a. informant's Neme/Ralationship			19b. Mallin	g Addresa (Straa					Stata. Zio Co	ode)
S	end 2 selth e n 27 is		Theodore W. Goss	sard/Fath	ner	119 D	artmouth	Drive	е Над	erstow	Mary I	and 2	1742
5	Heer Herm ofthe		20a. Mathod of Disposition		20b. Pl	ace of Dispos	sition (Nama of		o nag		20c. Location -		
20	Peges nent of mt: If its iry or o		1 ☐XBurial 2 ☐ Cremetion 3 I 4 ☐ Donation 5 ☐ Othar (Spec		stata		natory or other pla n Memori		rk 3-	4-00	Hagors	town M	aryland
Baltimore,	artme pertan Injur		21. Signature of Funerei Sarvice Lice		Cedi					4 22	nager s	TOWIT, IN	ai y rano
Ba	permit. Pages 1 and 2 Department of Heelth e Important: if item 27 is any injury or other tra 2006.						Nama end Addr borne Fu 5 S. Con			St.Wi	lliamsp	ort.MD	21795
	e		23a. Pert1. Entar tha disaesa, or cor shock, or haart failure. List only	npiicationa that ca	used tha death	. Do not anta	r tha moda of dy	ing, such es	cardlec or	respiratory are	est,		pproximata tarval Between
	Physician			,								Ö	nset and Death
4	/Medical		immedieta Ceusa (Final disaasa or condition	Mu1	tiple M	laior T	Trauma					mi	inutes
и	Examiner		resulting in daath)	a		as a consequ							
	₽ #	Examiner	_									1	
	requires that the death certificete be executed een signed by the attending physician and hould be detached for use as the buriel-transit	Саш	Sequentially list conditions,	D	Dua to (or	aa a consequ	uance of):						
0	Sian (Ē	Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Disaase or injury									I	
8760,	physician the burie	dicai	that initiated events rasulting in death) Last	0.	Due to (or	aa a consequ	lance of):						
9	eath certific attending p	0		d									
Box	ath ca ttend or us	Physician/M		0.									
0	the a	/slc	Part II. Other significant conditions	contributing to dea	ath but not rasul	lting in tha un	darlying cause g	van in Part I.		23b. Dld to	obacco uae co	ntribute to th	e cause of death?
ď.	that the de									1 □ Y	es 2X No	3 Probab	oly 4 Unknown
S,	signed be del	by										I	
Vital Records,	v require been si should t	Completed								24a. Wes a perfor	n autopsy med?	availe	autopsy findinga ble prior to
ec	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	Pp.		·								of dee	letion of cause oth?
<u> </u>	The late he page	Sol								1 □ Y	as 2 No	1□Y	as 2 No
ita	Physicien: The this certificate ral director, pag	Be	25. Was casa refarred to medical axaminer?						of Death (Check only or	10)		
=	physic this co	ို	1⊠Yas 2□ No	Hospitei: 1 🗆 In	patiani 2 🖺 E	ER/Outpatient	3□ DOA Ot	her: 4□Nu	irsing Home	a 5 ☐ Rasid	ence 6 DOth	ar (Specify)	
2		ä	27. Mennar of Death 1 □Netural 5 □ Pending	28a. Data of (Month)	f injury n, Day Year)	28b. Tima of Injury	28c. Inju	ry et rk?			ow injury occur	111	
Sio	Attending it deeth.	Sati	2 ☑ Accidant invastigation	n February	28, 1999	7:15		Yes 2XX	No P	assenger	in motor	r vehicl	e accident
Division of	rector de l'esch	Certification:	3 ☐ Suicida 6 ☐ Could not I 4 ☐ Homicide datermined	28e. Piace o	of injury - At hor g, atc. (Specify)	ma, farm, stra	at, factory, office		28	f. Location (S City or Tow	treet and Numb n, Stete)	er or Rural R	outa Number,
	tal o				and Mt Ae				F	Rt 66 and	1 Mt Aetn	a Rd	
	To the Hospital or Attend within 24 hours efter deet! To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Processing Check only one) 1 ☐ Certifying Processing Proc	hyaiclan: To tha b minar: On tha bas and mann	sis of axamination	rledge, death on and/or invi	occurred at the ti astigation, in my	me, deta en opinion, deal	d place, an th occurred	d due to the c l et tha tima, d	euse(s) and ma lata and piace,	anner as state and dua to th	id. a causa(s)
	o the	Me	29ts. Signature and fittle of certifiar		-,		29c. Licen	sa nu <i>m</i> ber		2	9d. Data signe	d (Month, Da	y, Year)
	⊢ ≯ ⊢ ŏ		1 51	1,200	7/~								
			20 Name and address of person who	WWi	How	020)	DO1	002		l P	ebruary	, 20,	צענו
			30. Name and addrass of person who Edward W. Ditto,	·	•		Washing	top St	н	opreta	wn, MD	217	740
	Sta	10	31. Data filed (Month, Day, Year)		gistrer's Signatu		-			SCISCO	wii, FID	417	70
	ા Registr		MAR 0 2 19	399	2special	B.	Space	2					

State of Maryland / Department of Health and Mental Hygiene

				Certificat	e of	Death			Reg. No.	7	10111
	1. Decedent's Nama (First, Midd	lle, Last)						2. Date of Dec		Vaar	3. Time of Death
Physician /Medical	OTIV		GENUA			te.		MARCH	3, 199	9 Year	10:10 AM
Examiner	4a Facility Name (If not institution	on, give street and number)				4b. City, To	wn, or Lo	cation of Death	4c. County	y of Death	
	Salisbury Cente	er; Genesis E	ElderCar	е		Salis	sbury	y, Md.	Wico	mico	
Funeral Director	5. Social Security Number 577-16-0603	6. Sex 1 XM 2 ☐ F	e (In yrs. last birt	hday) If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Birt (Month, De 3 / 2 / 19	h Year)	9. Birthp Coun Wash	place (State or Foreign
ms 23s or 28s-f show rmust be nothed at neral Director	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside City Limits
be notified at Director	MD Wo	rcester		n City							1□ Yes 2 No
23a or 2 ant De n	10e. Street and Number 13320 Peacht	tree RD		10f. Zij	2184	12			10g. Citizen of U	SA	try?
el; or items 23s or 28s-f show Examiner must be notified at by Funeral Director	11. Marital Status 1 Nevar Married 2 Mar 3 Widowed 4 Divorced	If Yes Give		13. Was Dece	cify Cubi	lispanic Ori an, Mexicar Specify:	gin? (Spo i, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla Specif	ce - Amaric ick, White, o	
her than "natural", on it, the Madeal Exerc Completed by	15. Deceder	nt's Education est grade completed)	16a.	Decedent's Usu (Give kind of wo	al Occup	ation during mos	t of work	ina	16b. Kind of B	usiness/inc	dustry
a de	Elementery/Secondary (0-12)	College (1-4or	5+)	(Give kind of wo					Dedie	/TV 5) omnin
S S	12 17. Fathar's Nama (First, Middle,	(a at)	(Owner/C	per		r'n Nome	First, Middle,	Radio/		cepair
matic event, i	Nicholas						gelin		known)	ne)	
27 is mar r traumal	19a. Informant's Name/Relations Alma Genua			Meiling Addres							
ry or othe	20a. Method of Disposition 1 XBurial 2 Cramation 4 Donetion 5 Other (5		cemeter	Disposition (Ne y, cremetory or cont Mem	ther ple			3/6/99	20c. Location Davids		
my inju	21. Signaldin olyFuneral Service			22. Name a	nd Addre	ss of Facili	y Bu	rbage			
cian dical	23a Part 1. Enter the disease of shock, or heart Jaliums. List Immediate Ceuse (Final disease or condition		d the daath. Do n	ot enter the mod				erlin, M or respiratory ar		1 3 3 3 1 1	Approximete Interval Between Onset and Death
	resulting in death)	1	Due to (or as a	onsequence of)	1					/	
the burial-transit	Sequentially list conditions, if any, leading to immadiata ceusa. Enter Underlying	5 b.	Due to (or as a c	consequence of)	42					1	9-7-
· ×	Cause (Disease or Injury that initiated events resulting in death) Last	c	Dua to (or as a c	onsequance of):							
d for us	Part II. Other significant condition	one contributing to don'th h	ut not requiting in	the underlying	nouna air	en in Bad I		22b Did	ohacco una cr	antribute to	the cause of death?
be detached for us by Physician/	rath. One agmicant condu	ons contributing to death b	ut not resulting in	the underlying t	æuse giv	en in rait i					bebly 4 Unknown
should									en autopsy rmed?	ava	ere eutopsy findings ailable prior to impletion of cause death?
Page 2								101	res 2 No	1[Yes 2□ No
Be C	25. Was cese referred to medica	ıl				26. Place	of Deat	h (Check only o	n <i>e)</i>		
I director, pag	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	tpatient 3 D	Oth Oth	ier: 40 Nu	rsing Ho	me 5 Resid	tence 6 □Oti	her (Specif	'y)
	27. Manner of Death 1 A Naturel 5 Pending 2 Accident Investi			ime of njury M	28c. Injui Woi 1 🗆	yat rk? Yes 2□		28d. Describe t	now injury occu	rred	- 123
lo by	3 Suicide 6 Could 4 Homicide determ	not be nined 28e. Place of Inj building, et	ury - At home, far c. (Specify)	rm, street, factor	y, office			28f. Location (S City or Tox	Street and Num vn, State)	ber or Rura	al Route Number,
completely filled in by		ng Physician: To the best Examiner: On the basis of and manner ste	examination and								
Me Me	29b. Signature and title of certifie	- 1	1	29	c. Licens	e number			29d. Date signe	ed (Month,	Day, Year)
	1/1/	XV4		_ D	2934	9			1/7	199	7
	30. Nama and address of parson	who completed ceuse of d	eath (Item 23a) (2334	9			11	11	
20	WILLIAM ROBINS				ALIS	BURY,	MD.	21804			
State	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature								
Registrar	MAR 0	1 1333	pris p	J. 100	ack	2					

- destruit - Sale II

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death 27,1999 LINWOOD CARL GRAU FEBRUARY 1700 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BERLIN If Undar 24 Hrs. 312 WEST STREET WORCESTER 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Yaar) Birthplaca (Stata or Foraign Country) M 20 F Min Months Days Hours Yrs. 15-03-5440 Usual Rasidence of Deceden MD 10d. inslda City Limits 10a State 10b. County 10c. City. Town or Location 1 Yas 2 No MD. WORCESTER BERLIN 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? STREET 21811 312 WEST USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Detes: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritai Status Black, White, atc. 1 ☐ Never Married 2 ☐ Married 1 □ Yas 2 No Specify: 3 Widowad 4 □ Divorced WHITE 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) ELECTRICIAN PUBLIC UTILITY 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) WILLIAM G.P. EMMA LOU BALDWIN 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 312 WEST STREET BERLIN Mp., 21811 KEN A. GRAU 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Gramation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) SALISBURY CREMATORY SALISBURY, MD. 21. Signature of Funeral Service Licens 22. Nama and Address of Fecility ULLRICH FUNERAL HOME BERLIN, 21811 MD. 23a. Part v Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta intarval Batwaan Onset and Deeth Immediata Ceusa (Final disaasa or condition resulting in death) pulmonery deserve Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown myocord, el 24b. Wara autopsy findings availabla prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examiner

attending physician and for use as the buriel-transit

signed by the a

Aftar this certificate has funaral director, page 2

Hospital or Attending Physician: 24 hours efter death. Funeral Director: Atter this certifice

To the Hospital or Atterview within 24 hours after der To the Funeral Directo complately filled in by the

Physician/Medicai

ò

Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Pagas 1 end Department of Haalth Important: If Item 27 any injury or other tr ance.

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

Pagas 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Haalth and Mental Hyglens. In this fifem 21 is marked other than "nutural; or items 23a or 28a-f ahow into or other traumatic event, the Medical Examines in the notified at

Baltimore, Maryland 21215-0020

Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disaase or Injury that initiated avants rasulting in daath) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

25. Was case reterred to medical exeminer? 1 Yas 2 No 27. Menner of Deeth

5 Pending invastigation

28a. Data of Injury (Month, Day Year) 6 Could not be daterminad

28b. Time of

28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Phyeicien: To tha best of my knowledga, daath occurred at tha tima, deta and place, and dua to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et tha time, data and placa, and dua to the causa(s) and mannar stated.

29a Cartifiar 29b. Signature and title of certifier

1 Natural

2 Accidant

3 Sulcida

4 Homicide

29c. License number

29d. Data signed (Month, Dav. Year)

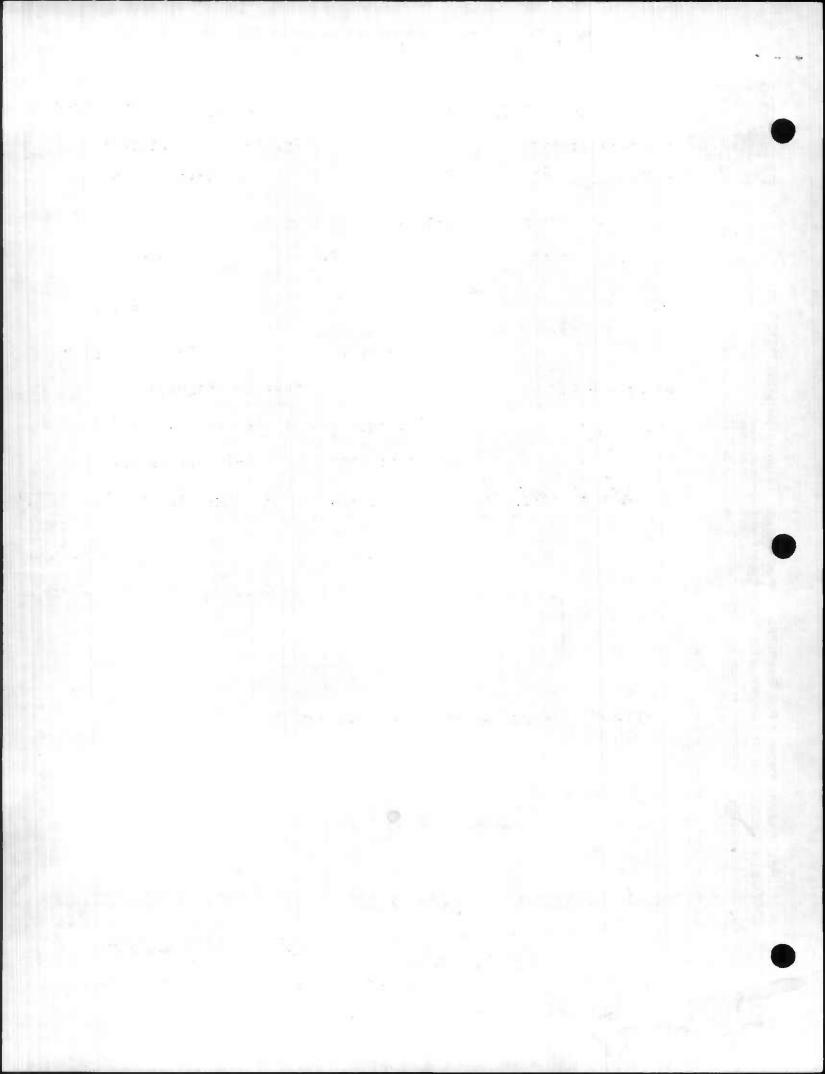
30. Name and eddress of person who of now

SICICO ausa of death (Itam 23a) (Type, Print)

State Registrar

31. Dete filad (Month, Day, Yaar) MAR 0 1

9733 32. Pegistrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

A11	mailas no	11.				Certifi	cate o	f Death		Reg. No.	00	
	Discretelan	1. Decedent's Neme (First,	Middle, Las	(1)					2. Dete of De Month	eath Dey	Yeer	3. Time of Death
	Physician /Medical	BRIAN THO	OMAS	HULL					March	02, 199	9	2:01 P.M.
	Examiner	4a Fecility Neme (If not ins						4b. City, Town, or				
		Washington			al			Hagerst		Washi		
	Funeral	5. Social Security Number	6. S	9x 7. M 2□ F		Me	Under 1 Yea onths Day		(Month, D	ay, Year)	Birthple Countr	ace (Stete or Foreign
	Director	218-86-7908 Usuel Residence of Decede			30	Yrs.			NOV. 2	4, 1968	MA	ŔYLAND
	and and	10e. Stete 10b. C			10c. Cit	y, Town or Location	n				10	d. Inside City Limits
	the Maryland 28a-f ehow	MARYLAND	VASHIN	ICTON			НΔС	GERSTOWN				1 ☐ Yes 2 ☒ No
	r 28a-f	10e. Street end Number	WINITE	AO TOTA		1	Of. Zip Code	DITIOTOMIA		10g. Citizen of N	Whet Countr	ry?
	death with the ms 23a or 28a creast be not	9629 GARIS S	SHOP R	COAD. APT	. 1A			21740			U.S.A	
		11. Maritel Status		12. Wes Decede Armed Force		,S. 13. Was	Decedent of	Hispenic Origin? (Suben, Mexican, Puer	Specify Yes or N	0- 14. Rac	e - America	n Indien,
0	or its		Married	1 X Yes 2	□ No		es 2⊠N		to ritali, etc.)		ck, White, et	IC.
00	urs urs		orced	Year or Date	s:		65 22219	o specify.		Specify		ITE
21215-0020	ed within 72 hours ygjena. ner than "natural", rt, tra Medical Ext Completed by	15. De (Specify only	cedent's Ed	ucation de completed)		16e. Decedent's (Give kind	of work don	upetion e during most of wo red)	rking	16b. Kind of B	usiness/Indu	ıstry
121		Elementery/Secondery (0)-12)	College (1-4d	or 5+)					T AVDY CA	DE GO	MD AND Z
	be filed with ntal Hygiena. d other than event, pre M	12 17. Fether's Name (First, M	iddle Last)			LAWN	TECH	NICIAN 18 Mother's Na	me /First Middle	LAWN CA		MPANY
an	nital H ed out			ит т							10)	
Maryland	d 2 should be filed within th and Mental Hygiena. The marked other than traumatic event, the March To Be Comp	THOMAS FRAN 19a. Informent's Name/Rel				19h Mailing A	Idraes (Stra	et and Number or R	A. WELS		State Zin (Code)
Ma	0 m = m	THOMAS F. H						URT, FRED				
e,	Hea Hea	20e. Method of Disposition	ODD/F.	ALIUA	20b. F	Place of Disposition	(Name of		Date	20c. Location		
Baltimore,	ages ant of tr: If it y or o	1 ⊠ Burial 2 □ Crem 4 □ Donation 5 □ Ott			te	ONCIDODO			2/5/00	DOONIGDO	NDO M	AADSZI ANID
=======================================	permit. Page Department of Important: If any Injury or once.	21. Signeture of Funerel Se			DU	ONSBORO (Iress of Facility	3/5/99	DOONSBO	DRU, M	IARYLAND
B	permit. Departiment import any injustice.	D SA DA	Jel	TITE.		DAC		ERAL HOME		ld Natio		
		23a, Part 1. Enter the disea	P2 St	even Dar	ifelt	J.C.			Boonsb c or respiratory	oro, Mar	ryland	Approximete
	Physician	23a. Part1. Enter the disea shock, or heart feilure	. List only	one ceuse on eecl	h line.							Interval Between Onset end Deeth
	/Medical	Immediate Ceuse (Final)		*						
	Examiner	disease or condition resulting in deeth)		e	Dunial	wy	00.00				-	
L.					Due to (c	or es a consequen	e ory.				1	
	ate be executed hysician and the burial-transit	Sequentially list conditions		b	Due to (c	or es e consequenc	e of):					
ó	an ar inal-t											
68760,	ficate be execu-	Ceuse (Disease or injury thet initieted events resulting in death) Last	5	C	Due to (c	r as e consequenc	e of):					
	S G S											
Box	at the death certification of the attending statement for use a Physician/M			d								
0. E	the at the at the def	Pert II. Other significant co	nditiona co	entributing to death	but not res	ulting In the under	ying cause	given In Pert I.	23b. Did	tobacco uae co	ntribute to	the cause of death?
Ρ.	that the de delached detached								1	Yes 2 No	3 Probe	ably 40 Unknow
18,	8 6 8 A										T 0.45 144-	- Continue
oro	The law requires sate has been sign, page 2 should be Completed by									s en eutopsy ormed?	evei	re eutopsy findings ileble prior to apletion of cause
ec	@ W CV											leeth?
A F	Con								1/2	Ves 2□No	1/2	Yes 2□ No
Vital Records,	ysician: The Last certificate he director, page	25. Wes case referred to m examiner?	-	Hospital W					eth (Check only	one)		
of	2 2 2	1 Yes 2 No		Hospital: 1 Inp		ER/Outpatient 3	LIDUA		-	idence 6 DOth		1. 16
L C	ding P. After funer funer	27. Menner of Deeth 1 Naturel 5	ending	-1/	Dey Year)	28b. Time of Injury	28c. In		28d. Describe	how injury occur	Ted	bject diver
Sign	Attending or death. octor: After by the fune iffication	2 Accident 3 Suicide 6 0	nvestigation Could not be	12/17	7	0550 AM		Yes 2 No	28f. Location	(Street and Numi	tar or Burni	Boute Number
Division	rs after death el Director: After led in by the funers Certification:	4 ☐ Homicide	letermined	208. Fieda of	etc. (Specif	ome, ferm, street,	ectory, offic	a	City or To	wn, State) Ro	cherry	Rood off
	filled C	29a. Certifier 1□ Ce	rtifying Phy	(sician: To the be	st of my kan	Wedge death on	urred at the	time, date end place	a end due to the	CAUSE(S) STOP	enforce	Maryla
	n 24 hound no Funer pletaly fill	(Check only 2X Me			of examine			opinion, deeth occ			end due to	the ceuse(s)
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funeral Medical Certification	29b. Signeture end title of o	artifier	4 . 4	/		29c. Lice	nse number		29d. Date signe	nd (Month, D	Dey, Year)
	->-0	1-The	1	UZ	d		0.	C.M.E.		March 0	3, 199	99

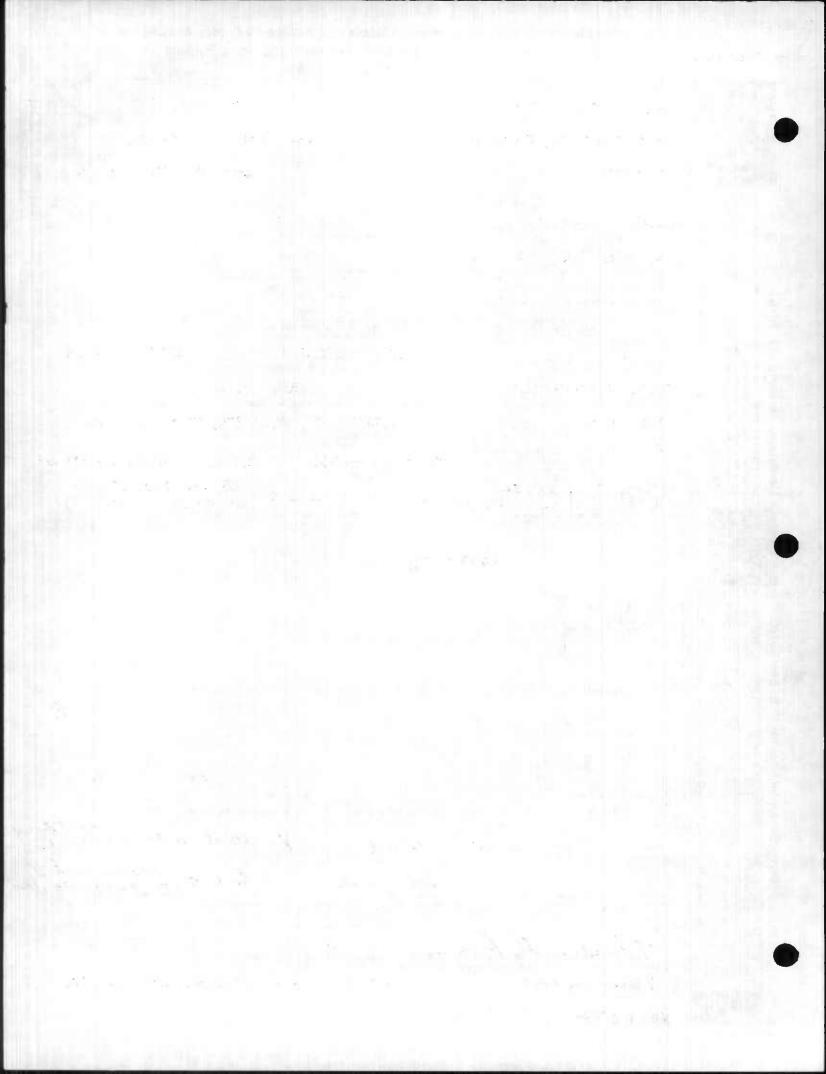
State Registrar

7 tower Miking
31. Dete filed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signature

111 Penn Street, Baltimore, Maryland 21201

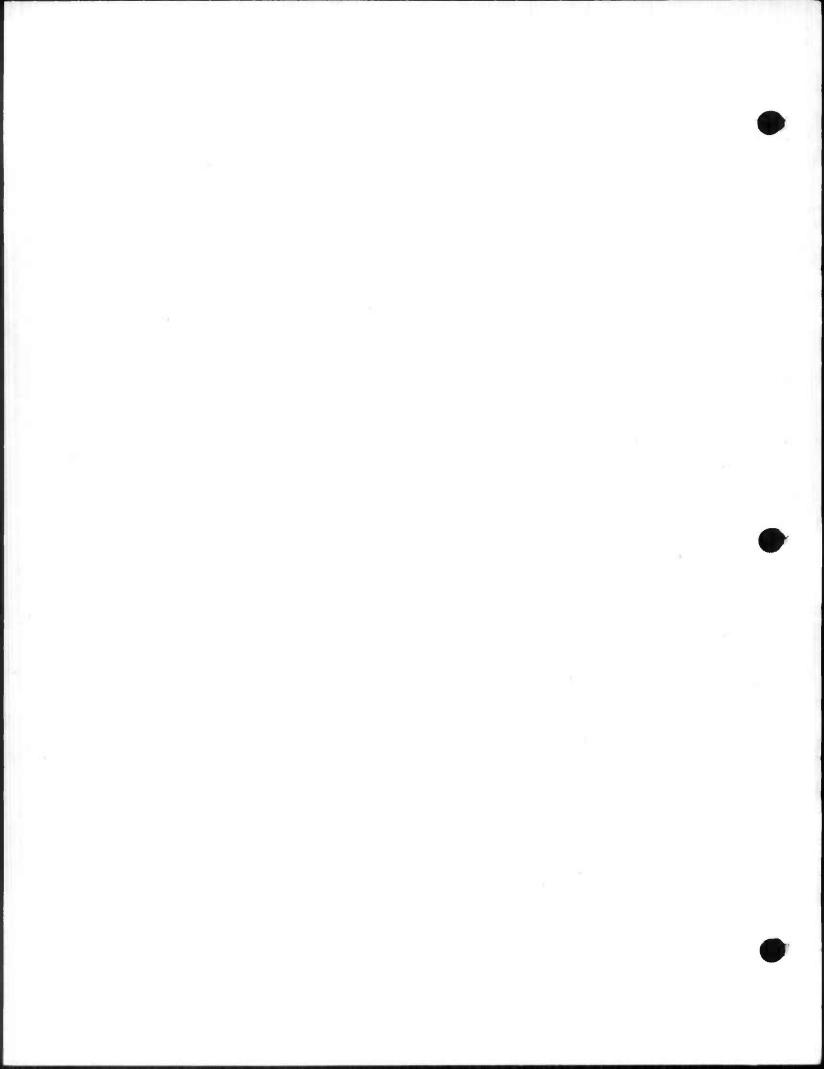


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
--

	FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle,			-		2. DATE OF DEATH		3. TIME OF DEATH
	-leorge/	narion Har	- hourt			3 2		9 11:15 PM
1	4. SOCIAL SECURITY NUMBER 578-18-9205		75 vss	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution,	1 M 2 F	11101			Aug. 20,1		Maryland
Œ	College View	give street end number) Center			erick	EATH	9c. COUNTY	
16	RESIDENCE OF DECEDEN			1100	ELICK		rre	derick
DIRECTOR	10e STATE 10b CC	fferson	10c. CITY,	town or Locat	IORRY			10d. INSIDE CITY LIMITS?
			- 11					1 YES 2 NO
FUNERAL	Route 01, Box	1241		10f	25425		10g. CITIZEN	N OF WHAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	NIC ORIGIN? (Specify Yes	or No — 14	. RACE — American Indien, Black, White, atc.
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 VES	TES	1 TYES		on, Puerto Rican, atc.)		Specify: White
	15. DECEDENT'S	1942-1948	16a. DECEDENT'S L	ISLIAL OCCUPATIO	NA.	16b. KIND OF BUS	200000000000000000000000000000000000000	
COMPLETED	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4 or 5+)	(Give kind of wo	ork done during mo	st of working	100. KIND OF BU	SINESS/INDUS	THY
P	unknown	Consider (1-4 of 3 T)	Plumb:	ing Engi	neer	Plumb	oing	
Ö	17. FATHER'S NAME (First, Middle, Las	0				ME (First, Middle, Maiden		
BE (rick Harbourt			Sarah	Elizabeth	Tarr	
5	190. INFORMANT'S NAME (Type/Print) Dorothea Martha	a Harbourt	Route	01, Box	nd Number or Rural I	noute Number, City or Tow Harpers Fer	n, State, Zip Co	V 25425
	20e. METHOD OF DISPOSITION	20b.	PLACE AND DATE OF					y or Town, State
	1 Buriel 2 Cremation 3 4 Donetion 5 Other (Specify)	Removal from State ceme	nps Crematory or oth	er place)		3/3/99		ester. VA
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE		22. NAME AN	D ADDRESS OF FA	CILITY		ester, VA
	* gran	S. (mist	an	Melv	n T. St	rider Co.,	Inc.	
	23. PART I. Enter the diseases.	or complications that caused	tha daath. Do no	ot anter tha mo	da of dylng, auc	Charles 1	ratory arrest	t, Approximate
	shock, or hasrt fall IMMEDIATE CAUSE (Final	ure. List only one cause on as	ich line.					Interval Between Onset and Death
	disease or condition resulting in death)	· PNI www.	ČL.					7 clas
		DUE TO (OR AS A						1993
8	Sequentially list conditions,	b. aspiration						months
AT	if any, leading to immediate cause. Enter UNDERLYING	QUE TO TOR AS A	CONSEQUENCE OF)	:				
윤	CAUSE (Disesse or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF)	:				
CERTIFICATION	reaulting in death) LAST	d						
	PART II. Other aignificant cond	itions contributing to death by	it not resulting in	the underlying	cause alven la	Part I, 24a. WAS AN	ALFRANCY	
CAL	Parking sun's	Cerebel casa	du dis	() A	Cause given in	PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDI	4.1.	1 1 -	MIND - UM	V37		1 _ YES 2	1 0	OF DEATH?
Z.		PUTRIBUTE TO CAUSE OF	F DEATH YES		LINICEDTAIN			1 YES 2 NO
A	25. WAS CASE REFERRED TO MEDICA		6. PLACE OF DEATH		ONCERIAII	, []		
SICIA	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpe		OTHER:	5 Residence	6 Other (Specify)		
PHY	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJ		28d. DESCRIBE HOW II	NJURY OCCUR	RED
ВУ	1 Natural 5 Pending 2 Accident Investigat		INJU		ES 2 NO			
ED	3 Suicide 8 Could no		— At home, farm, str	reet, factory, office		281. LOCATION (Street & City or Town, State)	and Number or i	Rural Route Number,
		, d						
JP.		PHYStCIAN: To the best of my knowle						
COMPLET	2 MEDICAL EXA	MINER: On the basis of examination	end/or investigation.	, in my opinion, de	eath occured at the	time, date end placa, and	d due to the co	ause(e) and manner ae stated.
BE	29b. SIGNATURE AND TITLE OF CERT	IFIER			29c. LICENSE NUN	IBER	29d. DATE SI	IGNED (Month, Day, Year)
10	JU MA	wyn w			1271	01	> 3/	299
	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DEA	1	Print)	(1	12 . 1	0 -	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE A	un.	HULL	ck hd	7100	1
	MAR 0 9 19		B.	Ana V	,			
				with the sales				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ruth Elizabeth HARBAUGH /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Washington County Hospital 5. Social Security Number If Under 1 Year 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours Yrs Director 232-01-9230 84 Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23s or 28s-1 show other traumstic event, the Medical Examinar must be notified at Director Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 207 S. Hall 21782 Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 11 Marital Status 72 hours after 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced

College (1-4or 5+)

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

1 ☑ Yas 2 ☐ No 10g. Citizen of What Country? U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian Black, Whita, atc. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Homemaker Her own home

2. Data of Death

June 27 1914

Month
Te Drugny dix
Peath | sc. County of Death Day

28 1999

Washington

Maryland

3. Time of Death

2130

Birthplace (State or Foreign Country)

10d. Inside City Limits

17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) William G. Dorsey Beulah M. Hammersla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)

John Harbaugh - Husband 207 S. Hall Sharpsburg, Maryland 21782 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Ramoval from State

4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/2/99 Hagerstown, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Facility Minnich Funeral Home

23a. Part1. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 415 E. Wilson Blvd. Hagerstown, Maryland

Immediate Cause (Final diseasa or condition rasulting in death)

Approximata Intarval Batween Onset and Death will Selendans

Examine Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Completed

Be 2

al Hygiene.

Departit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg. Important: If them 27 is marked other any injury or other traumers.

Physician /Medical

Examiner

physician and the burial-transit

has

death.

To the Hospital or Att within 24 hours after of To the Funeral Direct

by

Completed

Be

2

Certification:

Medicai

L112abeth

ar Daugh,

Dua to (or as a consequence of):

23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 ☐ Yas 2 ☐ No

1 Yas 2 No 26. Place of Deeth (Check only one)

25. Was casa rafarred to medical examinar? Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 12 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of fnjury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred

1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicida

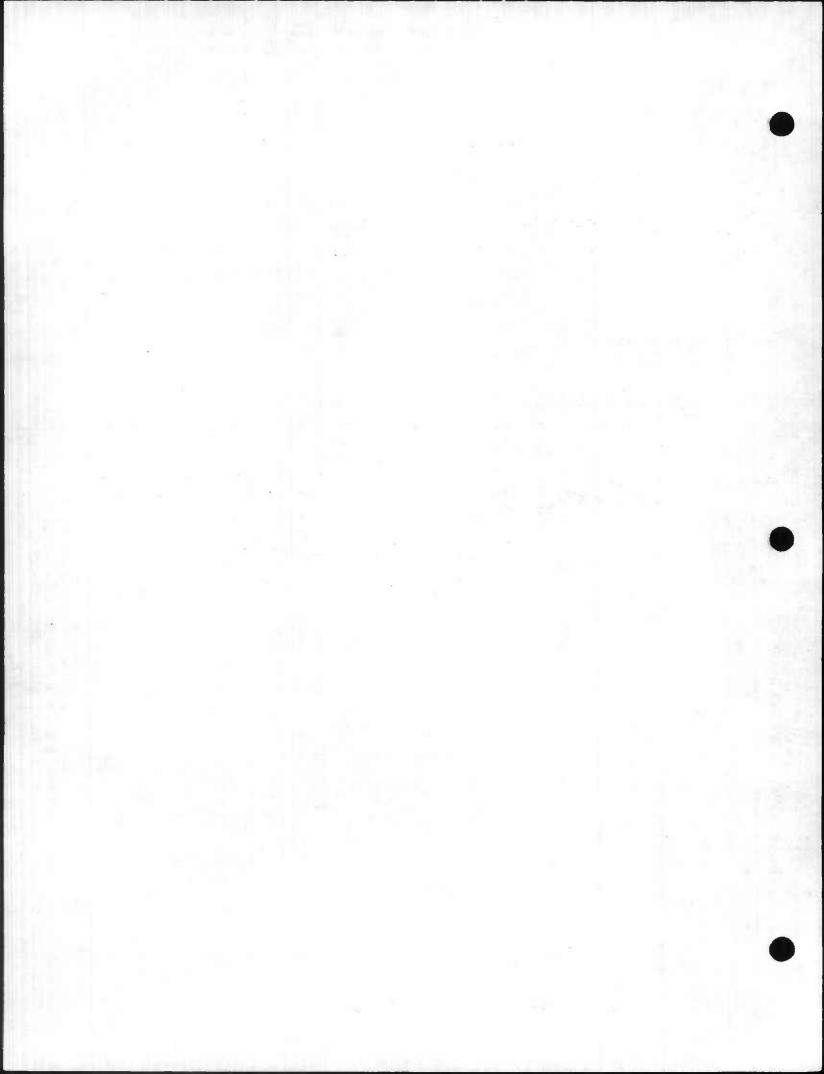
1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, deta end place, end due to the cause(s) and manner as steted. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stelled. (Check only one)

29b. Signatura and titla of cartifier 29c. Licensa number 29d. Data signed (Month, Day, Year)

mn 30. Nama and address of person who completed causa of daath (ftam 23a) (Type, Print)

Boonsboro 2031 32. Registrar's Signatu

State Registrar



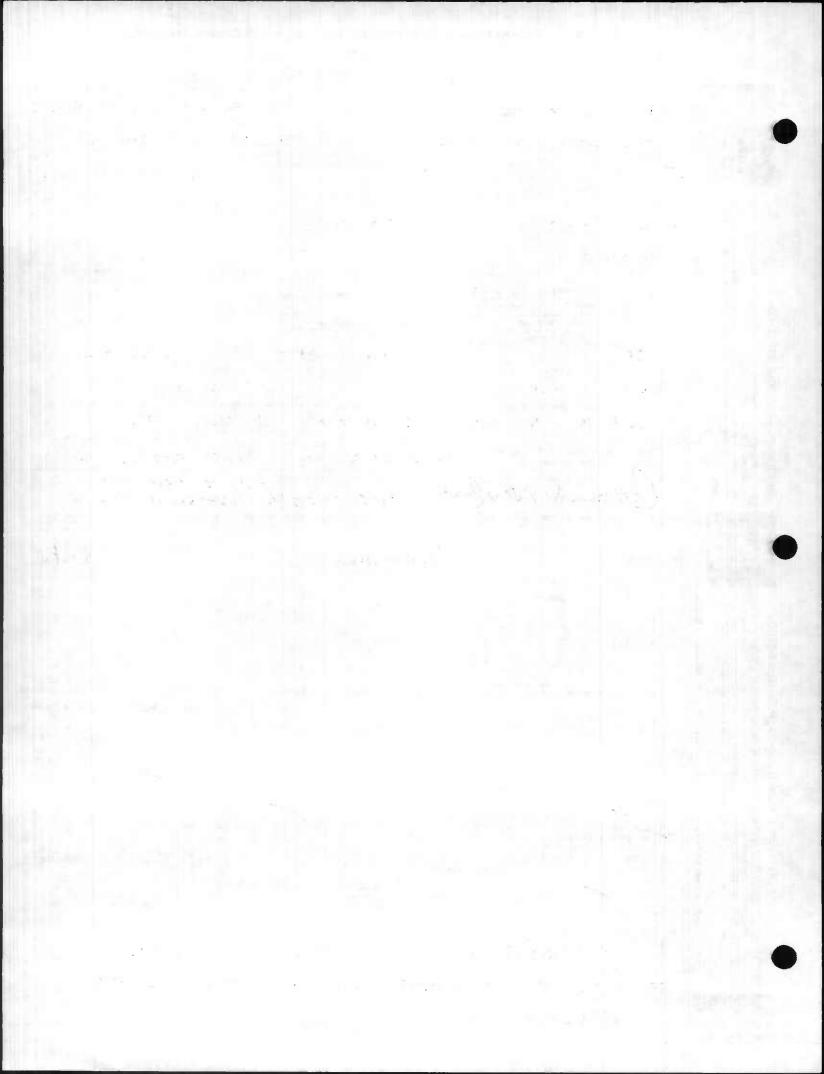
Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** 1999 February 6:25PM Rosalie Agnes Harne /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Northampton Manor Nursing Home Frederick Frederick If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Yaar) If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sax Birthplaca (Stata or Foraign Country) **Funeral** 1 □ M 2 🖾 F Months Days 89 215-34-3860 Yrs. 1909 South Carolina Director Usual Rasidanca of Decedent with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at 1 X Yas 2 □ No Directo Frederick Libertytown Maryland 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 9021 Walnut St. 21762 U.S.A. Funeral death 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, spacify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Peges 1 and 2 should be filled within 72 hours after a Department of Heelth and Mental Hygiane. Important: if them 27 is marked other than "natural", or its any injury or other traumatic event, the Medical Exertine Ance. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: White þ 3 X Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16e. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 clerk/cashier retail store 18. Mothar's Nama (First, Middla, Meiden Surnema) 17. Fathar's Nama (First, Middla, Last) George F. Spencer Annie Cavanaugh 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 6801 Buffalo Rd. Mt. Airy, MD 21771 George F. Harne, Sr./ son 20b. Placa of Disposition (Nama of cematary, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Mt. Olivet Cemetery 3/3/99 Frederick, MD 4 □ Donation 5 □ Othar (Specify) 22. Nama and Addrass of Facility Hartzler Funeral Home 21. Signature of Funeral Sarvice Lines Marin Libertytown, MD 21762 11802 Liberty Rd. 23a. Part1. Enter the disease, or complications that caded the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Interval Batween Onset and Death **Physician** Immediata Causa (Final diseese or condition rasulting in death) /Medical Nummia Examiner Dua to (or as a consequence of): Examiner physician and s the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Due to (or es a consequança of): Box 68760, Physician/Medical Dua to (or as a consequence of): 98 use ed by the e 23b. Did tobacco use contribute to the csuae of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Ware autopsy findings evailable prior to complation of cause of death? 24a. Was an autopsy performed? Completed Seu 1 Yas 2 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director. Be 25. Wes case refarred to madical axaminar? 26. Placa of Daath (Chack only ona) Hospital: 1 Yas 2 No Other: Nursing Homa 5 Residence 6 Other (Specify) 9 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) funerel 28c. Injury at Work? 28d. Dascribe how Injury occurred 27. Manner of Death 28b. Tima of Certification: Natural 5 Panding 1 ☐ Yas 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af Investigation 2 Accidant 6 Could not be detarmined 28a. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 | Homicide 29a. Cartifian Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and placa, end dua to the causa(s) and manner as steted. edical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner steted. (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifie 3-01-99 D31058 M 30. Nema and engless of person who completed cause of deeth (Item 23a) (Type, Print) ASHE, 10200 Coppermine Road, PO Box 6 Woodsboro, MD MD

Registrar

MAR 0 2 1999

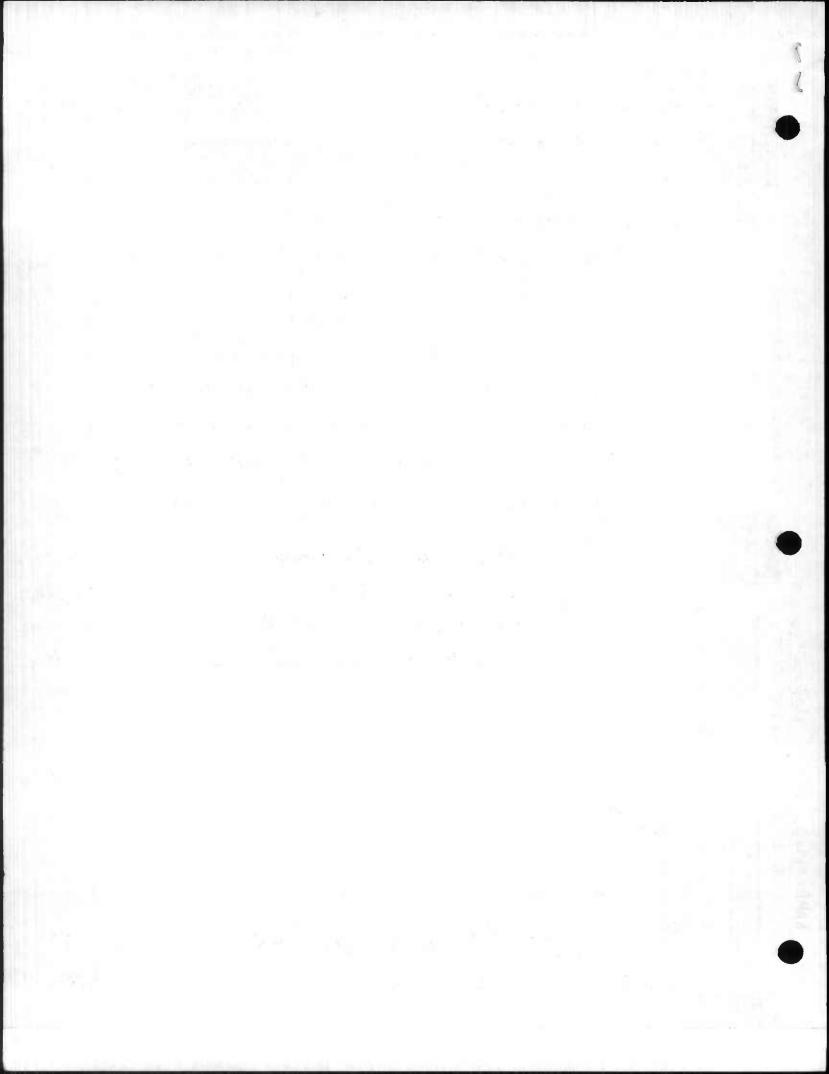
31. Data filad (Month, Day, Year)

32. Ragistrer's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 3, per Phy. Certificate of Death 3/1/99, Carroll County, wjl 1. Deçedant's Nama (First, Middla, Last) Month **Physician** HAIFLE 25 1999 166 /Medical 2:00 p.m. 4a. Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Baltimore Health Corre If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. Birthplace (Stete or Foraign Country) 7. Aga (In yrs. last birthday) 5. Sociel Security Number **Funeral** 1□ M 2 F Yrs. 212-03-4025 **Director** Usual Rasidance of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "netural", or Items 23a or 28a-1 show any Injury or other traumatic evant, the Medical Expriser matter pages. 1 Nas 2 No CArroll Westminster Director MAryland 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? PARK Dr USA BAldwin 2115 A-4 406 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Detas: 10☑ Navar Married 2☐ Married 1 ☐ Yes 2 KNo Specify: Specity: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest greda completed) 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working
lifa. DO NOT usa retired) 16b. Kind of Businass/Industry CArroll County Court Elamantary/Secondary (0-12) Collega (1-4or 5+) Recorder 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Franklin Haifley Helen Josephine LOUIS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Virginia Mc Neil 10609 Graeloch CT LAurel MD 20723 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Dete 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 3/1/99 HAMPSTEAD, Carroll Cremation 22. Name and Addrass of Facility Prills Functal Home and Chapel, P.A. 21. Signature of Funaral Sarvice Licenses 412 Washington Rd Westminster mD 23a. Part. Enter the disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such es cardiac or respiratory arrast, shock or heart failure. List only one cause on each line. Approximeta Interval Batwaen Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In death) /Medicai Examiner Examiner ten Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last and physician a s the burial-Physician/Medical ue to (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown ò 24b. Wera autopsy findings availabla prior to complation of cause of daath? 24e. Was en eutopsy performed? Completed 1 Yas 1 TYAS 2ENO 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 1 Thpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 T Homicida To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla of certifiar 29c. License number 12595 St April Hospital 900 Cation Avenue 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) allah Mustapha 32. Registrar's Signatura Registrar



ITem 2	Pleas	•	Black Indelible Ind / Department Certificate	of Health and	Mental Hygie	ne	ole.	1.0
Tremz	Decedent's Nama (First, Middia)		Certificate	OI DeallI	Reg. 2. Data of Death	No.	3. Ti	me of Death
Physician		HARRISON	JR			Day	Year	1924
/Medical Examiner	4a Facility Nama (If not institution,		V/C	4b. City, Town, or		4c. County of		127
LXAIIIIIEI	ST AGNES	HEALTHCAR	e	BALTIN	mre		NIA	
Funeral Director	5. Social Security Number	6. Sex 1 M 2□ F	Yrs. If Under 1 Months I	Year If Under 24 Hrs Days Hours Min.	(Month, Day, Ye	nar) 1, 1999	9. Birthplace (S Country)	State or Foreign
p .	Usual Residence of Decedent 10a. Stete 10b. County	10e Ci	ty, Town or Location				10d los	ide City Limits
the Marylar 288-f show notified at	MD N	I/A	BALTIMOR		Las	0	1)	Yes 2 No
Office death with the Meinter death with the Meinter of theme 23e or 28e-f einer must be modified Funeral Director	10e. Street end Number	SLYVANIA AVE		21201		Citizen of Wi		
Aaryland 21215-0020 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, and Mental Hygiene, is marked other than "natural", or ferms 28 or 284-6 show reumstic event, the Medical Examples must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Nevar Married 2 Merrie 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes, 2 No If Yes, Give Year or Detas:	J,S. 13. Was Deceder If Yes, specify	nt of Hispanic Origin? (S y Cuban, Mexican, Puer No Specify:	pecify Yes or No- lo Rican, etc.)		- American Indi , White, etc. BLAC	an,
ind 21215-002 be filled within 72 hours tal Hygiene, d other than "natural; event, fire Medical Ex-	15. Decedent's (Specify only highest Elementery/Secondery (0-12)	s Education grade completed) College (1-for 5+)	16a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during most of wor retired)	rking 16b	. Kind of Bus	iness/Industry	
Maryland 212 d 2 should be filed with th and Mental Hyglene. T's marked other than traumatic event, me II To Be Comp	17. Father's Neme (First, Middle, L MICHAEL	HARRISON		18. Mother's Nar	me (First, Middle, Maid	den Sumame)	
Baitimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or any injury or other traumette event, the Medical Examples. To Be Completed by F	19e. Informent's Neme/Relationsh St. Ag nes Hea 20e. Mathod of Disposition 1 Burial 2 Cremation 4 Donetion 5 Other (Sp 21. Signature of Funerel Service L Catty Berg 23a. Pertl. Enter the disease, or c shock, or heert feilure. List o	Hheare 3 Removel from Stete 20b. 1 5 + icensee	900 S. Call Place of Disposition (Name cometery, crematory or other. Agnes Hea 22. Name and St. Agnes	Address of Facility nes Hear Caton	Baltimos Date 4-16-99 5-199 K theare Ave, Ba	Baltin	DD 21 City or Town, Sti more,	ZZ9 ate MD 2122
Physician /Medical Examiner Parallel Examiner Examiner	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, laceding to immediate cause. Enter Indentition	e. Extrem Due to (or as a consequence of): Or as a consequence of):	maturi, ery	f		Onse	al Between and Death
ecords, P.O. Box 68760 law requires that the death certificate be as been signed by the attending physicial is 2 should be detached for use as the buringleted by Physician/Medical is	Cause (Disease or injury that initiated events resulting in death) Last		or as a consequence of):					Let
P.O. B. that the death of the atte detached for Physicia	Pert II. Other significant condition	e contributing to death but not res	sulting in the underlying cau	se given in Part I.			tribute to the ca	ause of death?
Division of Vital Records, F or Attending Physicien: The law requires tha after death. Director: After this centificate has been signed in by the funeral director, page 2 should be deertification: To Be Completed by F					24a. Wes an a performed	utopsy 17	24b. Were aut available completic of death?	prior to on of cause
II Records, F. The law requires the take has been signed page 2 should be de Completed by F.					1 ☐ Yes	24 No	1 ☐ Yes	2□ No
Vision of Vital I Attending Physicien: The rideath. After this certificate by the funeral director, pag iffication: To Be Co	25. Was case referred to medical exeminer?	Hospitel:		Other	ath (Check only one)	•		
Oivision of Vortering Physical Oracle Cash Chartel	1 Yes 2 No	1 Sinpatient 2L	ER/Outpatient 3 DOA 28b. Time of 28c	4 Nursing I	fome 5 ☐ Residence 28d. Describe how i			
ion ath. r: After e funer	1 Natural 5 Pending 2 Accident Investige		Injury M	2. Injury at Work? 1 ☐ Yes 2 ☐ No	33.3.3.0 HVW	1-1, 0000110		
Division of the or at a factor of the transfer	3 ☐ Suicide 6 ☐ Could no determine	of be ned 28e. Plece of Injury - At h building, etc. (Special	come, ferm, street, factory, of	office	281. Location (Stree City or Town, S	t and Numbe tate)	r or Rurat Rout	e Number,
NAME To the Hospital within 24 hours a To the Funeral Icompletely filled	29a. Certifier (Check only one) 1 Certifying 2 Medical	Physician: To the best of my known on the basis of examination and manner steted.	owledge, death occurred at attion and/or investigation, in	the time, date and place in my opinion, death occu	e, and due to the causured at the time, date	e(s) and men and place, ar	nner as stated. nd due to the co	nuse(s)
To the comp comp	29b. Signeture and title of certifier	_		License number	29d.	Data signed	(Month, Day, Y	(ear)
	· Ma	WM		0053609	M	arch	/,	1999
	30. Name and address of person w Joseph Santo	ro, M.D. 5+.	Agnes Heat	heave, 900	S. Caton	Are.	Boiltim	21229

State Registrar 31. Date filed (Month, Day, Year) MAR 3 - 1000

32 Registrar's Signature

1. Sports

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedant's Nama (First Middle Last) 2. Data of Daath 3 Time of Death Month Yaar 1105 TEBEUARY 26 1999 MINNIE HORNER 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Sacurity Number If Undar 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Days Hours 1 □ M 2 1 F Yrs. Virginia 222-01-6252 September 21,1921 Usuai Rasidance of Decedant 10a Steta 10b County 10c. City, Town or Location 10d. Insida City Limits Maryland Wicomico Bivalve 1 Yes 2√ No 10e. Street end Numbar 10f. Zip Code 10g. Citizan of What Country? 21245 Nanticoke Rd. 21814 USA 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 220 No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amaricen Indien, Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yas 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry (Specify only highast grada complated) Elementary/Secondery (0-12) College (1-4or 5+) Shirt Mfg. Co. Seamstress 17. Fethar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) William Mason Hilda Fluhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Russell Horner/Husband 21245 Nantiocke Rd., Bivalve, MD 21814 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovat from Stata Wicomico Memorial Park 3/1/99 4 ☐ Donation 5 ☐ Othar (Specify) Salisbury, MD 21804 21. Signatura of Funaral Sarvice/Licensea 22. Nama and Address of Fecility Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cadsa on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Onsat end Death Immediata Causa (Final CARDING SUDDEN DEATH SECONDARY to ANGIODIASTY disaasa or condition rasulting in daath) I HR. Dua to (or as e consequence of): CARDIOMYOPATHY 5 4R. Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaase or injury that initiated evants rasulting in daath) Last Dua to (or es a consaguance of): 104R INSULIN REQUIRING DIABETES Mellitus Due to (or as e consequence of) 5 4R ATRIAL FIBRILLATION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? 2 No 25. Was cesa raferred to medical 26. Piece of Deeth (Check only ona)

Physician /Medical Examiner

Department of Health er Important: If item 27 is any injury or other trau

Physician

Examiner

Funeral

Director

28a-f show

items 23s or 28s-f short ner must be notified at

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"natural",

Hyglena.

d 2 should be filed with end Mental Hygler 7 is marked other th

Director

Funeral

by

Completed

the Maryland

Baltimore, Maryland 21215-0020

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/Medical

attending physician end for use as the burial-tran signed by the a d be datached f

The law requires that the death certificete be axecuted Box 68760, page 2 s certificate Hospital or Attending P1
 124 hours aftar death.
 Funeral Director: Aftar it letaly filled in by the funeral To the Hospital or A within 24 hours after To the Funeral Directon pletaly filled in b

Physician/Medical P.0. Records, þ Be Completed Vital Certification: To To Division

> State Registrar

edicai

27. Manner of Death 1 Natural 2 Accidant 3 ☐ Suicide 4 ☐ Homicida

29b. Signature end titla of

29a. Certifier

1 Yas 2 No

5 Panding invastigation

28a. Deta of Injury (Month, Day Year)

1105

28b. Time of Injury

Hospitat: 1 Inpatiant 2 ER/Outpatiant 3 DOA 28c. fnjury at Work? 1 Yas 2 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred STEUT DISPIACEMENT DUSERTHMIA

28a. Place of Injury - At home, farm, streat, factory, office suitiding, atc. (Specify)

| Cartifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and manner as stated.

| Cartifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and manner as stated.

2-27-99

29c. Ucensa Jumbe 09 450497

29d. Data signad (Month, Day, Yaar)

SALISBUTY, MO 21801

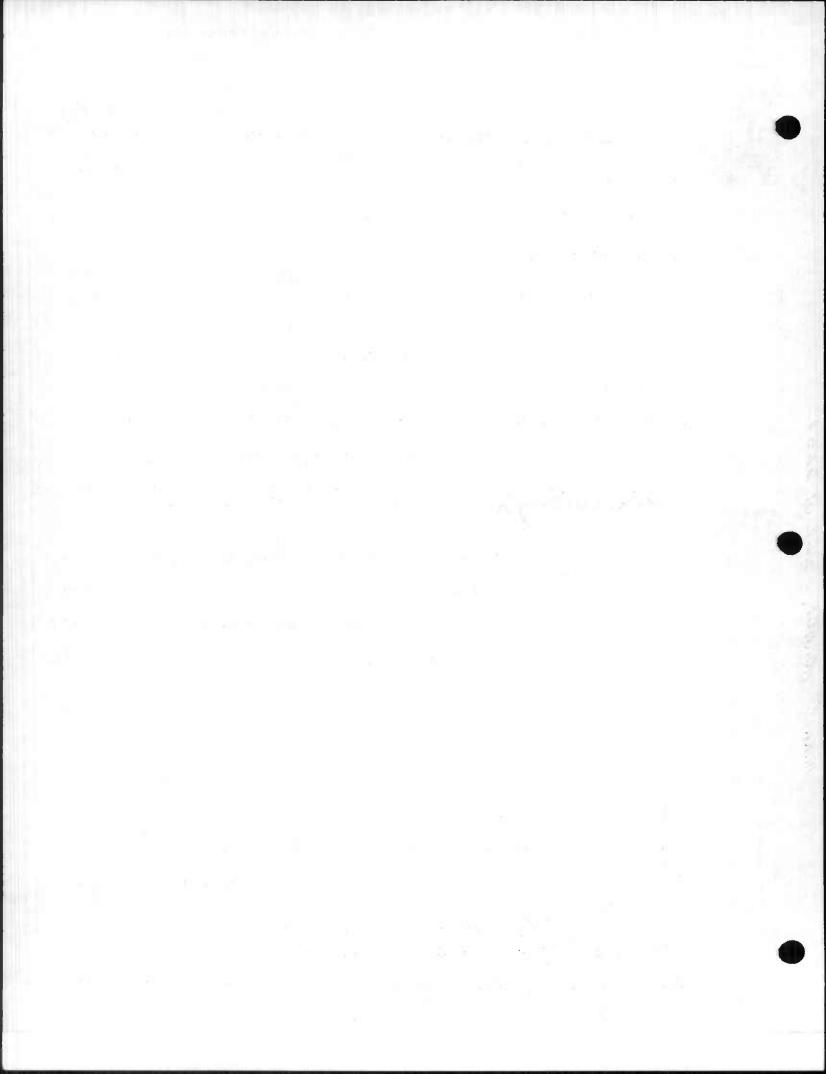
DIME 0.0 30. Name end addrass of parson who completed ceusa of deeth (Item 23e) (Type, Print)

Chris Snyder ome
31. Data filed (Month, Day, Year)

MAR 0 3 1999

John Mclean, M.D. 32. Registrar's Signatura

PRMC 100 E CAITOIL ST



Please Type or Print in Biack indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 3 **Physician** Reese Hollowar /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and pumber) 4c. County of Death **Examiner** HOSPITAL BERLIN WORLESTER Atlantic General If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) if Undar 1 Yaar 6 Say 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** 1₩ 2□ F Months Days Yrs. 100 Director 221-05-5200 March 6, 1898 Maryland Usual Rasidanca of Decedant with the Maryland 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 1X Yas 2 No Delaware Wilmington Director New Castle 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Madical Examiner must be r Van Buren St., Luther Towers 19806 USA Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☑ Yas 2 □ No If Yas, Giva Yaar or Datas: Army 14. Raca - American Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. 1 Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: White à 3 Widowad 4 Divorced Army Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Chemical Mfg. Co. Security Guard 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Emily B. Riley Greensbury F. Holloway 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Elizabeth H. Hampel/Niece 513 Jackson Ave., Wilmington, DE 19804 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Injury or 3/5/99 Parsonsburg, MD 4 ☐ Donation 5 ☐ Othar (Specify) Forest Grove Cemetery 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Ar shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medicai Examiner Dua to (or as a consequence of) Examiner physician end the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiatad evants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequanca of) 98 esn 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed After this certificate has 1 🗆 Yas 2 NO 1 ☐ Yas 2 ☐ No Division of Vital or Attanding Physician: 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 2 1 Yas 2 No ↑ Inpatiant 2 □ ER/Outpatient 3 □ DOA 28d. Dascribe how injury occurred 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant ofter deatl Director: 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 24 hours e Hospital 29a. Certifian 1 🗹 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. edicai (Check only one) 2 Medical Examinar: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the P within 2 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cartifian 3 My SICIEN

State Registrar 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

DURKIN DO.

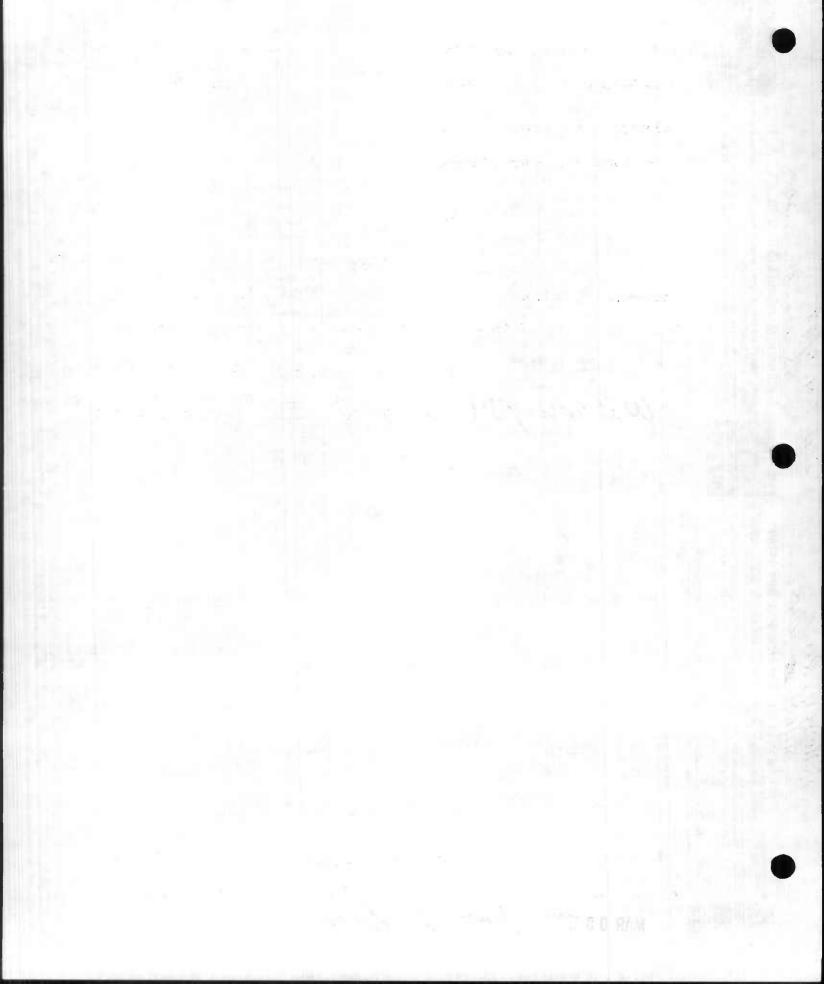
31. Data filed (Month, Day, Year)

MAR 0 3 1900

9733 HEALTHWAY

3. Ragistrar's Signatura

BERLIN MD 21811



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Time of Death Month. Day Royal Albert Johnson 1999 0 26 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) NOV . 1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 470-30-4103 Hours 12XM 2□ F 67 Yrs. Minnesota Usuat Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 No Washington Co. Hagerstown Maryland 10f. Zio Code 10e. Street and Number 10g. Citizen of What Country? 19014 Rock Maple Drive 21742 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indian, Black, White, etc. 11 Maritai Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Life Actuary Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Johanna Ulvestad Albert Johnson 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19014 Rock Maple Drive, Hagerstown, Maryland 21742 Mary V. Johnson/Wife 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other piece) 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery Mar. 5 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Luce 23a Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last 170515 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Tyes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

tem 27 is marked other than "natural", or frama 23a or 28e-f show other traumatic avent, the Medical Examinar must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient important: If filem 27 is marked other that any injury or other traumatic avent, that page.

the Maryland

death

filed within 72 hours aftar

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be

physician and the burial-transit usa sate has been signed by page 2 should be detect certificate Certification: To this After or Attanding death. Director: • Funeral Di-letaly filled in

Records, P.O. Box 68760

Rayal Alber

John son,

25. Was case referred to findical	
examiner?	н
1 Yes 2 No	
27. Manner of Death	

1 DNaturai

3 Suicide

29a. Certified

one.

4 ☐ Homicide

ospitet: Inpatient 5 Pending investigation 2 Accident

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be 28e. Place of Injury - At home, tarm, street, tactory, offica building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28c. Injury at Work? 1 TYes 2 No

28d. Describe how injury occurred 28t. Location (Street and Number or Rural Route Number, City or Town, State)

10 certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signat

29c. License number 220 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

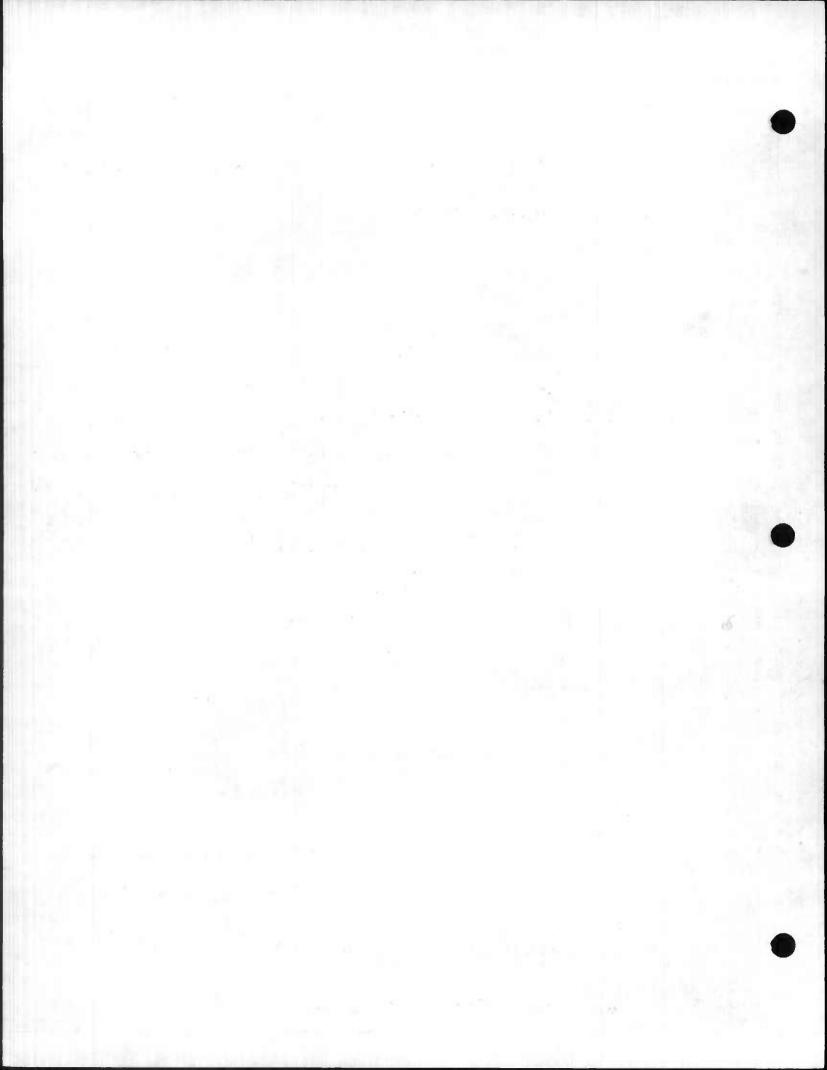
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within 2

31. Date filed (Month, Dey, Year)

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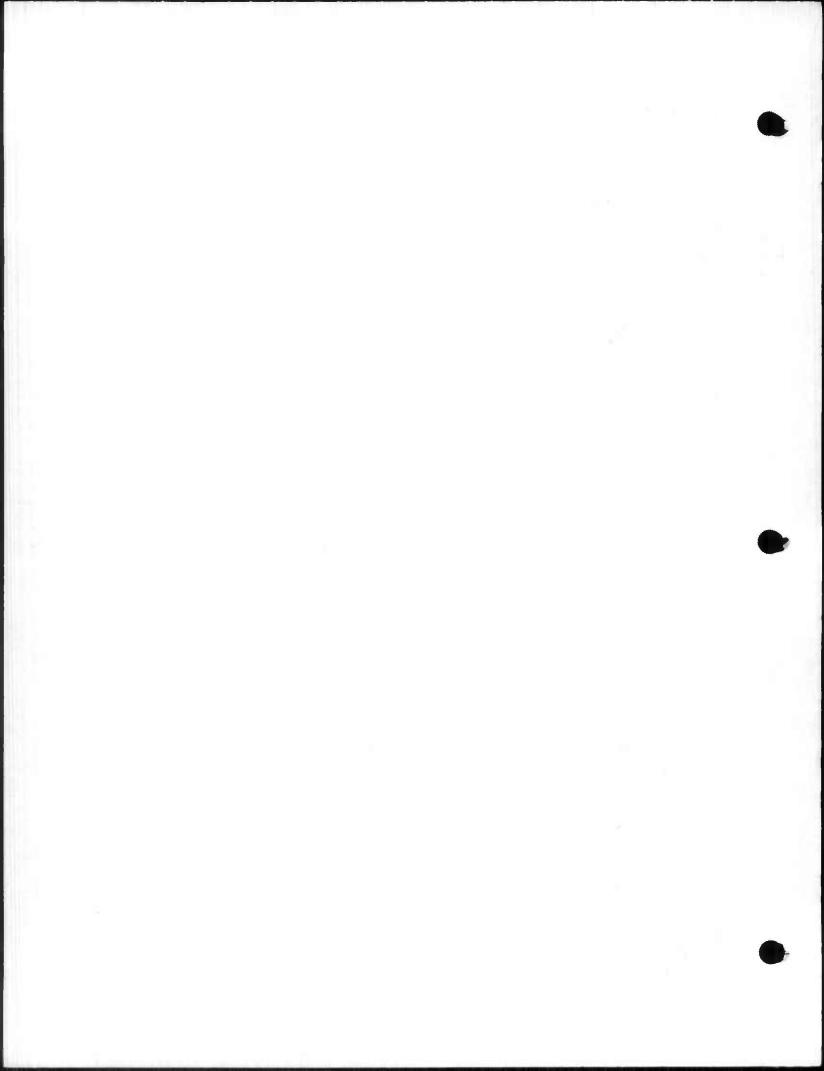
32. Registrar's Signature



DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1. DECEDENT'S NAME (First, Middle, L		TITT T TARE		TUDOD			DAY	YEAR	3. TIME OF DEATH
	RUSSELL 4. SOCIAL SECURITY NUMBER		WILLIAM		JUROD		February	24,19	999	9:45 PM M
	216-34-0335	5. SEX	6. AGE (In yrs. last		IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1014	8. BIRTH Country	PLACE (State or Foreign y)
	9a. FACILITY NAME (If not institution, (ive street and number)			9b. CITY, TOWN	OR LOCATION OF D	October 16		Ma NTY OF D	ryland
DIRECTOR	MANOKIN MANOR					CESS ANNE				RSET
ÆC	10a. STATE 10b. CO			10c. CITY,	TOWN OR LOCA	TION				10d, INSIDE CITY
		merset		Pr	incess	Anne				LIMITS? 1X YES 2 NO
FUNERAL	11974 Edgehil	l Terrace			10	1. ZIP CODE 21853			IZEN OF W	/NAT COUNTRY?
FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDER	T EVER IN U.S. ARI	MED	13. WAS DEC	CENDENT OF HISPAI	NIC ORIGIN? (Specify Y	es or No-	14. RACE Black	— American Indian,
BY	3 Widowed 4 Divorced	IF YES, GIVE	MAR OR DATES		1 TYES	3 2 NO Specif	y:		Specif	^{γ:} White
TED	15. DECEDENT'S (Specify only highest (EDUCATION rade completed)	(Gr	ve kind of wo	SUAL OCCUPATI	ON ost of working	16b, KIND OF B	JSINESS/INC	DUSTRY	
COMPLET	Elementary/Secondary (0-12) UNKNOWN	College (1-4 or 5	+)	termai	*		Seafoo	od		
OM	17. FATHER'S NAME (First, Middle, Last					16. MOTHER'S NA	ME (First, Middle, Maide	n Surname)		
BEC	unknown					unknow				
5	19a. INFORMANT'S NAME (Type/Print) Lucy Butler/Gu	ardian					Route Number, City or To de Dr., Sa			MD 21901
	20a. METHOD OF DISPOSITION		20b. PLACEA	ND DATE OF	DISPOSITION /N		DATE 20c. L			
	1 Donation 5 Other (Specify)		- Salis		Cremato	ry	2/25/99	Salisb	ury, N	MD div
	21. SIGNATURE OF FUNERAL SERVICE			-	22. NAME A	ND ADDRESS OF FA	Harre Profe	ssional	L Asso	ciation
		in CF			501 S	now Hill Ro	d., Salisbury	y, MD 2	21804	
	1	or complications the re. Liet only one ce	it caused the dec use on each line.	eth. Do no	t enter the mo	ode of dying, suc	h as cardiac or rea	olratory an	reat,	Approximata Interval Between
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		1 0 1/2/4	CPA >	. 01	VV (a		8 16	1		3
J	resulting in death)	DUE TO	OR AS A CONSE	UENCE OF):	el Ca	remama	of Esap	hagi	w	1 year
NO	resulting in death) Sequentially list conditions,	- a.	(Off No A CONSES	DENGE OF).		remoma	of Esap	hagi	w	1 year
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	- a.	OR AS A CONSED	DENGE OF).		remana	of Esap	hagi	us)	1 year
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BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other algnificent conditions of the condition of the cause	DUE TO C. DUE TO d. L. HOSPITAL: 1 Inpatient 2 (Month, L. 28a. DATE Of (Month, L. 28a. PLACE Of building, d. 14YSICIAN: To the best of all the building. HINER: On the basia of a series of	OR AS A CONSED OF INJURY — At hone etc. (Specify) Type knowledge, dea xamination and/or in the consense of t	UENCE OF): UENCE	the underlyin (Check only one) THER: Nursing Hon OF 28c. IN. WY M 1 [] set, factory, offic at the time, data in my opinion, c	UNCERTAIN THE 5 Residence FURTY AT PARTY TYPES 2 NO THE	Part I. 24a. WAS A PERFC 1 YES 1 YES 5 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Yown, State to the cause(e) and mittime, date and place, a	N AUTOPSY RMED? 2 IN NO INJURY OCC and Number) inner se state ind due to th	24b. CURED or Rural Ru ted. te cause(a) E SIGNED (2 - 2	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 K NO Dute Number, and manner as stated. (Month, Dey, Year) 5 99
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other algnificent conditions of the condition of the cause	DUE TO C. DUE TO d. DUE TO d. DUE TO d. PLACE (be building, d) AVSICIAN: To the best of a NYSICIAN: To	OR AS A CONSED OF INJURY — At hone etc. (Specify) Type knowledge, dea xamination and/or in the consense of t	UENCE OF): UENCE	the underlyin (Check only one) THER: Nursing Hon OF 28c. IN. WY M 1 [] set, factory, offic at the time, data in my opinion, c	UNCERTAIN THE 5 Residence FURTY AT SPART TYPES 2 NO THE 10 NO	Part I. 24a. WAS A PERFC 1 YES 1 YES 5 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Yown, State to the cause(e) and mittime, date and place, a	N AUTOPSY RMED? 2 IN NO INJURY OCC and Number) inner se state ind due to th	24b. CURED or Rural Ru ted. te cause(a) E SIGNED (2 - 2	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 K NO Dute Number, and manner as stated. (Month, Dey, Year) 5 99



Please Type or Print in Biack Indelible ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Nema (First, Middle, Last) **Physician** Sylvia Frankel march Kurtz /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Devs Hours Months 1 M 2 F Yrs Director October 18, 1912 New 249 16 8938 86 Usual Residence of Decedent 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 258-71 Directo Maryland Williamsport Washington 10e. Street and Number

Ave.

1 Yas 2 XNo 10f. Zip Code 10g. Citizen of Whet Country? 21795 USA 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc.

Month

Reg. No.

Year

1999

Washington

Specify: White

16b. Kind of Business/Industry

4c. County of Death

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Self employed 17. Fathar's Nema (First, Middle, Last)

12. Was Decedent Evar in U.S. Armed Forcas?

1 Yes 2 No If Yes, Give Year or Detes:

Clothing Retail 18. Mother's Neme (First, Middle, Maiden Sumame) Seidel

Frankel Oscar 19e. Informent's Neme/Relationship (Type, Print) Richard O. Kurtz

16505 Virginia

1 Never Merried 2 Married

3 ₩idowed 4 Divorced

11. Meritel Stetus

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

3/4/99

E. Magnolia Ave. Hagerstown, Md.

Dete

20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 € Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signeture of Funeral Service Licensee

22. Name end Address of Fecility Gerald N. Minnich

1 Yes 2 No Specify:

305 N. Potomac St.

Charlotte, N. C.

20c. Location - City or Town, Stete

1 KIMMIC 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Funeral Home

Bertha

21740 Md. Hagerstown, Approximete Intervel Between Onsat and Death

Immediate Cause (Finel disaese or condition resulting in deeth)

Harris 23a or

8

I Hygiana.

permit. Pages 1 and 2 should be illad we Department of Health and Mental Hygien Important; if Nem 27 is marked other tha any injury or other treasment.

Physician /Medical

Examiner

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this

Director

n 24 hours a Hospital

within 2 To the

deeth.

Division or Attanding bengis

Physician/Medical

by

Completed

Be

Certification:

Medical

4 Homicide

29e. Certifie

Saltimore, Maryland 21215-0020

Franke

Sylvia

Funeral

88

2

Hebrew Cemetery

21742

3. Time of Deeth

9620

Birthpleca (State or Foreign Country)

10d. Inside City Limits

York

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Due to (or es a consequence of): Due to (or es a consequence of):

Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 12No 3 Probably 4 Unknown 1 Yes

24a. Wes an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

25. Wes case referred to medical exeminer? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

t Neturel 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

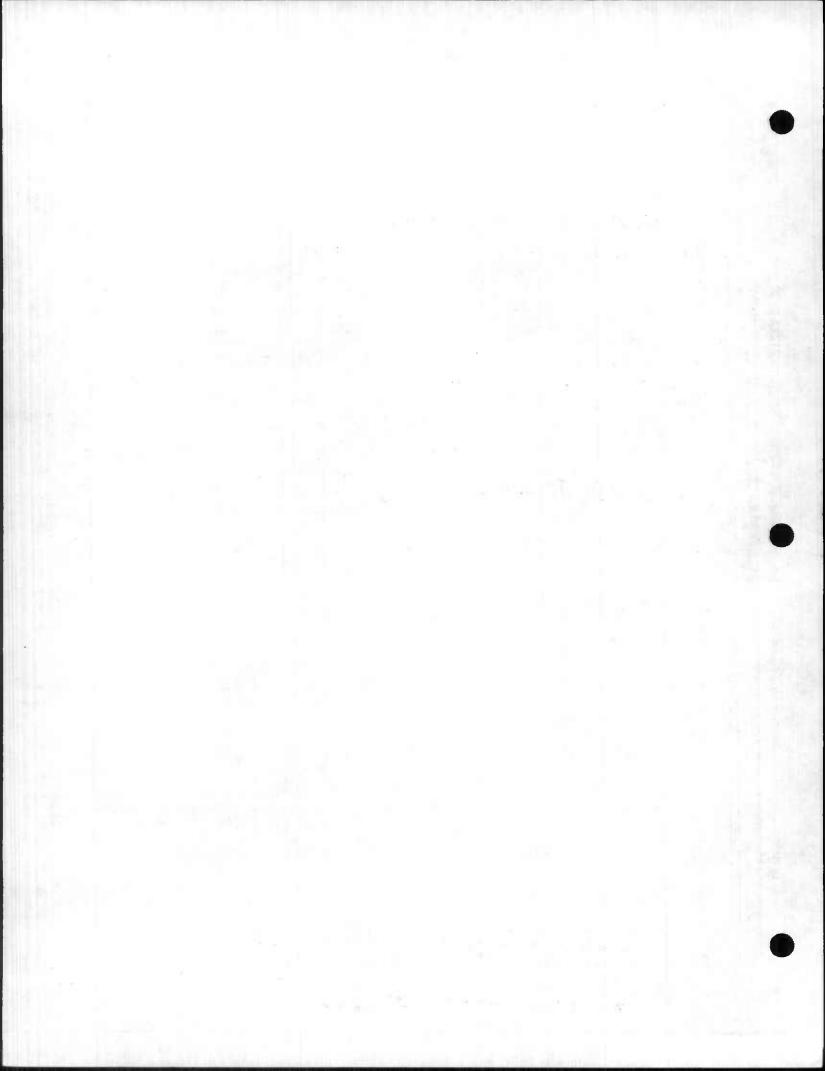
(Check only one) 29b. Signatura and title of certified

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end pleca, and due to the cause(s) and menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

30. Neme end address of person who completed cause of death (ttem 23a) (Type, Print)

CX-CAMER ROM

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Donald F. Leo rebruaru /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Co. Hospital Hagerstown Washington If Under 1 Ye If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months XXM 20 F 76 Director 069-18-1176 1/03/2 Buffalo, N.Y. Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director notified Pa Fulton Ft. Littleton 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? ð must be 548 SheepskimhHollow Rd. "naturel", or flerne 23a 17223 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cartographer US Dept. of Commerce 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Department of Health and Adental Important: If Nem 27 is mare any injury or d 2 should be the Prand Mental H 7 is marked off Be John J. Leo Laura Stosser 19a. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Leo wife 548 Sheepskin Hollow Rd, Ft. Littleton, Pa 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/1/99 McConnellsburg, Pa. Union Cemetery 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Kelso-Cornelius Funeral Home, Inc. odge 322 N. Second St., McConnellsburg, Pa. 23a. Part1. Effar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer feiture. List only one cause on each line. Approximeta Intarval Between Onset and Deeth **Physician** Months /Medical Immediate Causa (Finet disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate causa. Entar Underlying Ceuse (Disease or trijury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, Physician/Medical 2 Due to (or es a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown emoma þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical examiner? Be 26. Place of Death (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 INO 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 GNatural 5 Pending 1 Yes 2 No investigation 2 Accident Director 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, larm, street, lactory, office building, atc. (Specify) 24 hours after on Funeral Direct 4 Homicide ò 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. edical 29a. Certifier (Check only one) To the P 29b. Signature and title of certifie

State Registrar 30. Name and add

31. Dete filed (Month, Dey, Year)

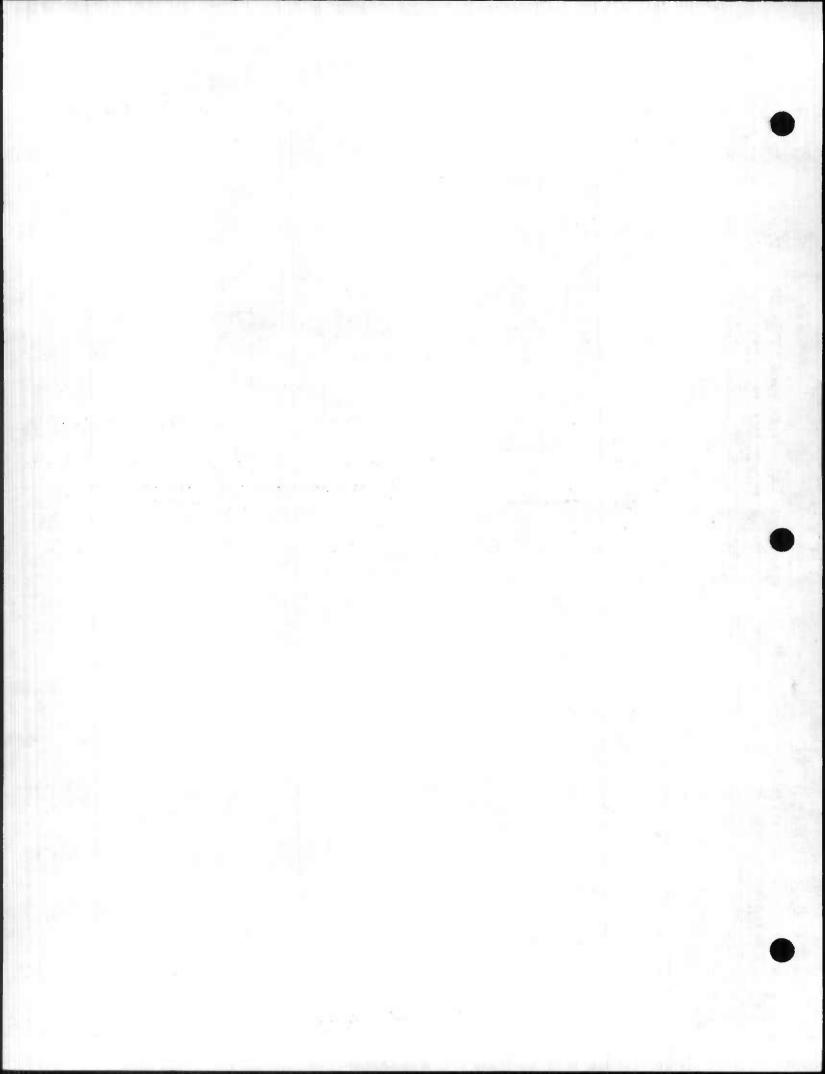
EB

ess of person who completed cause of death (Item 23a) (Type, Print)

2 6 1999

82. Registrar's Signeture

hill ave, HagerstonyMD21742



Director

Funeral

by

Completed

Funeral

Director

28a-f show traumatic event, the Medical Examiner must be notified at 6 items 23a ŏ "natural", permit. Pagas 1 and 2 should be filed within: Department of Health and Mantal Hygiane. Important: if Item 27 is marked other than "r any Injury or other traumetic event, the Man Since.

Physician /Medical Examiner

Examiner

þ

Baltimore, Maryland

P.O. Box 68760,

Records.

Division of Vital

Hospital

sician end buriai-transit attending physician for use as the bune Physician/Medical been signed by should be dated Completed pega 2 cartificeta or Attending Physician: funaral director. Medical Certification: To Aftar this efter death. filled in by the within 24 hours e To the Funeral C complately filled

Certificate of Death 1. Dacedent's Name (First, Middla, Last) 2. Dale of Death 3. Time of Death Month WALTER BERNARD LONG, JR. MARCH 03 1999 12:40 AM 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing and Rehabilitation Center Berlin Worcester 5. Social Security Number If Under 1 Year if Undar 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y 1/2/14 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1**X**M 2□ F 578-14-1648 Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnsida City Limits MD Worcester Ocean City 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 218 Hitchens Ave. 21842 USA 12. Was Decedent Ever in U,S. Armed Forcas? 14. Raca - American Indian, Black, White, atc. 11. Marital Status Was Decedeni of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 XYes 2 □ No If Yes, Give Yaar or Dates: 1 Never Marriad 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorcad white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dancer Entertainment 12 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter B. Long Lina Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhoda T. Long/ Wife 218 Hitchens Ave. Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory 3/3/99 Frankford, DE 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD plications that can sad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, one cause on sixth line. Approximate Interval Between Onsat and Death endinol Parevennia Immediate Cause (Final ruce. disease or condition resulting In death) Decubitace knde il -Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Last PINAT Bue to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Below Knee Amputation 25. Was case refarred to medical examiner?

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy parformed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yas 2 No

28d. Describe how injury occurred

1 ☐ Yas 2 No

26. Place of Death (Check only ona)

Other: 4X Nursing Home 5 Residenca 6 Other (Specify)

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

5 Pending investigation 6 Could not ba determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year)

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. Licanse number 29d. Date signed (Month, Day, Year)

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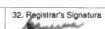
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) FEDERICO G. ARTHES, M.D. 46 TEAL CIRCLE

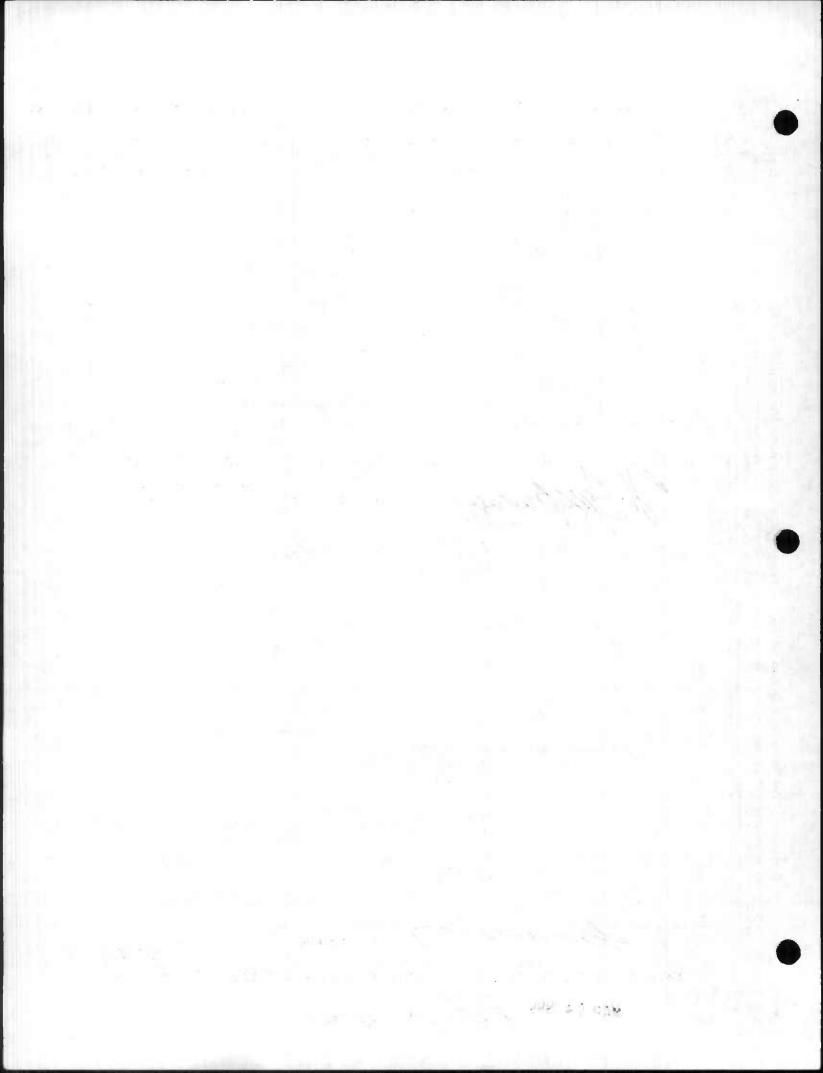
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BERLIN MD 21811

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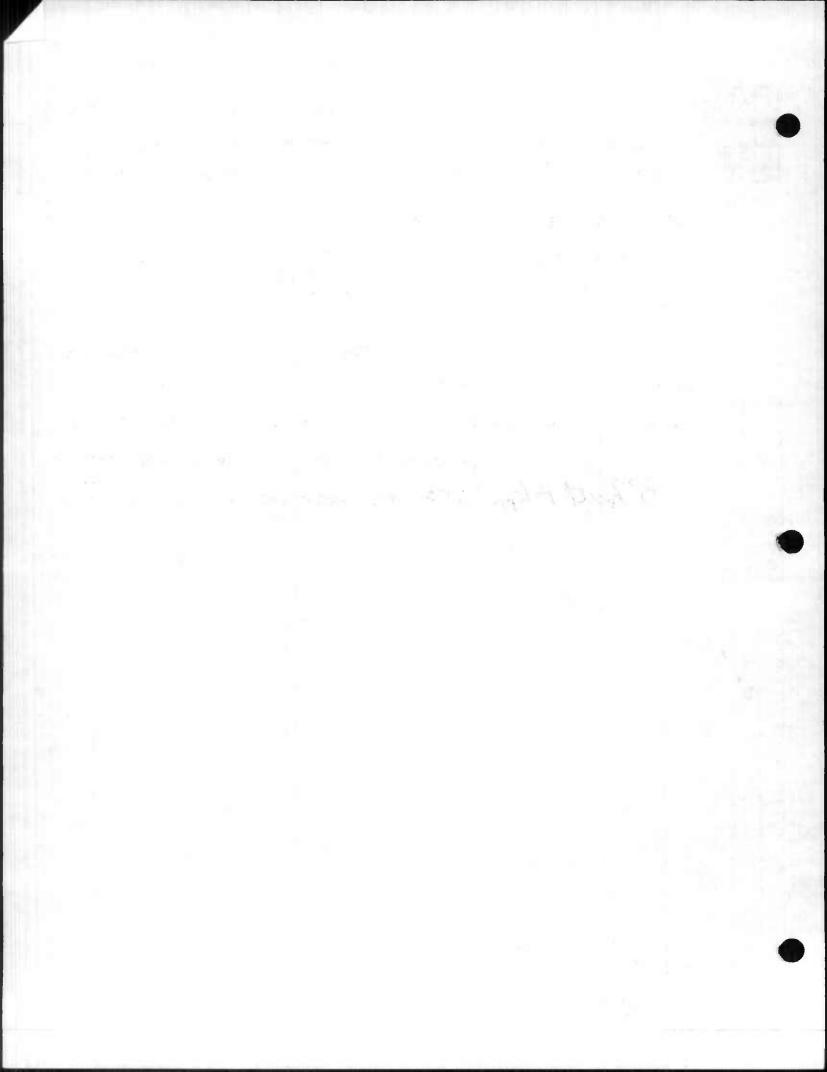
State Registrar 31. Date filad (Month, Day, Year) MAR 0 4 1999





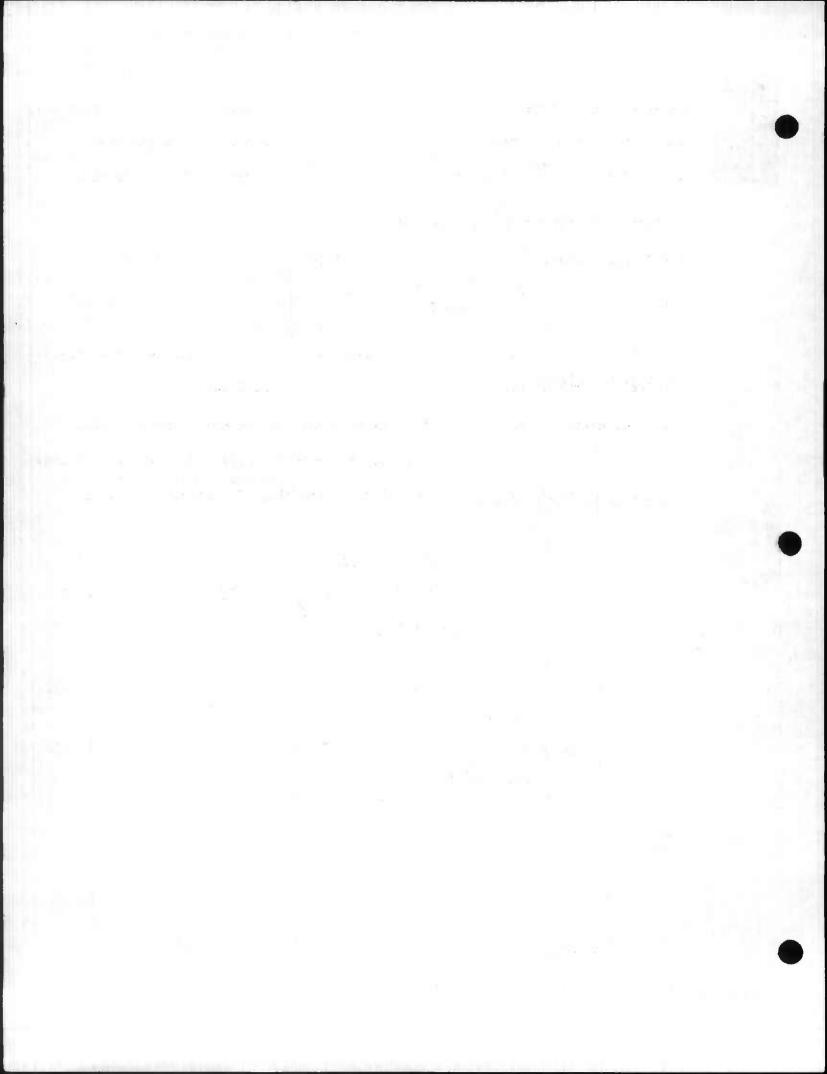
State of Maryland / Department of Health and Mental Hygiene 9 08 | 26

Physi						uc UI	Death		Reg. No.		
Physi		1. Decedent's Name (First, Middle, Las	st)					2. Date of De	ath		ne of Death
		RICHARD	L.		T. /	AYFIE	חז	Month FEBRUAF		Year Q 11	• 20 PM
/Med Exam		4a. Facility Neme (If not institution, give			L/			or Location of Deat			:20 PM
Funera	al	31678 PEGGY NECK 1 5. Social Security Number 6. S 213-24-1122	RD. ex 7. Age (In	yrs. lest birth	day) If Und Month	er 1 Year	PRINCES	S ANNE	SOMERSI		
pu *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town	or Location					Tanta .	
he Maryla 28a-f ahor	Director	MARYLAND SOMERSE			INCESS					10	de City Limits Yes 2∑No
1 P 8	눔	10e. Street and Number			10f. Z	ip Code			10g. Citizen of Wh	et Country?	
23e		31678 PEGGY NECK	RD			218.	53		U.S.A	Α.	
d within 72 hours efter death with the Manyland jiene. r than "natural", or Itema 23a or 28a-f ahow The Modreal Examinet must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	in U,S.			lispanlc Origin? an, Mexicen, Pu Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Race - Black, Specify:	American India White, etc.	n,
hou				160 5	None de mile I le				401 161 1 1 0 1	WHITE	
n 72	Completed	15. Decedent's Ed (Specify only highest gra		(Decedent's Us Give kind of w life. DO NOT	vork done	during most of w	vorking	16b. Kind of Busi	ness/Industry	
within lene. than "	E G	Elementery/Secondery (0-12)	College (1-4or 5+)		PIPEFIT		*/				7.00
e filed al Hygie other	ပိ	8 17. Father's Name (First, Middle, Last)		F	TEEFII	IEK	40 Mathada N	ame (First, Middle,		UNION #	/82
should be fand Mental I	Be							Name (First, Middle,	,		
should band and Menta	2	GEORGE		FIELD			HELEN		NOBLE		
2 sho end ls me		19a. Informant's Name/Relationship (7	Type, Print)	19b. l	Mailing Addre	ss (Street	end Number or	Rurel Route Number	er, City or Town, St	tete, Zip Code)	
1 end 2 Health em 27 I			YFIELD - SON	91			ECK RD.	PRINCES	S ANNE,	MD 218	53
permit. Peges 1 end 2 should be filed Department of Health end Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event,		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removel from State	cemetery	Disposition (No. cremetory or OGE CRE	other plea		Date 3-1-99	20c. Location - Ci		
permit. Departments any injury	NIE S	21. Signature of Funeral Service Licen	see A		22. Name a	and Addre	ss of Facility		705 E. MA	AIN ST.	
Jeath certificate be executed ettending physician end for use es the bunel-transit	edicai Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due	to (or as a co	nsequence of	·):					
0 0 9	3		d								
ette	(3)										
	Physician	Part II. Other aignificent conditions co	entributing to death but not	resulting in t	he underlying	ceuse giv	en In Part I.		lobacco uaa contr Ves 2⊡ No 3		
aw requires that the case is been signed by the 2 should be deteched	by	Part II. Other afgniffcent conditions co	ontributing to death but not	resulting in t	he underlying	ceuse giv	en in Part I.	1) X	Yes 2□ No 3 en eutopsy med?		4 Unknow
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The law requires that the cate has been signed by the page 2 should be deteched	e Completed by	25. Was case referred to medical examiner?	Hospital:	t resulting in t		Oth	26. Place of E	24a. Was perfo	en eutopsy med? /es 2 □ Mo	24b. Were euto available p completior of death?	4 ☐ Unknown Dosy findings rior to a of ceuse
fing Physicien: The law requires thet the c. h. After this certificate has been signed by the funeral director, page 2 should be deteche	To Be Completed by	25. Was cese referred to medicel examiner? 1 Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending Investigation	Hospital: 1 □ Inpatient 28e. Date of Injury (Month, Day Yee	2 □ ER/Outp	vatient 3⊡ [DOA Oth	26. Place of Der: 4 □ Nursing	24a. Was perfo	en eutopsy med? /es 2 □ Mo	24b. Were euto available p completior of death? 1 Yes	4 ☐ Unknown Dosy findings rior to a of ceuse
or Attending Physicien: The law requires that the cath therefor: After this certificate has been signed by the orbit timestor, page 2 should be detected in by the funeral director, page 2 should be detected.	Certification: To Be Completed by	25. Was cese referred to medicel examiner? 1 Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending	Hospital: 1 □ Inpatient 28e. Date of Injury (Month, Day Yee	2 ☐ ER/Outp 2 Bb. Tir Inji At home, farm	natient 3⊡ D me of ury M	OOA Oth	26. Place of E er: 4 □ Nursing y at k?	24a. Was perfo	en eutopsy med? /es 2 \(\) /es 2 \(\) /es 2 \(\) /es 2 \(\) /es 6 \(\) /es occurred Street and Number	Probably 24b. Were euto available p completion of death? 1 Yes (Specify)	4 ☐ Unknow osy findings rior to of ceuse 2 ☐ No
or Attending Physicien: The law requires that the cath therefor: After this certificate has been signed by the orbit timestor, page 2 should be detected in by the funeral director, page 2 should be detected.	Certification: To Be Completed by	25. Was cese referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physical Certifying Physical examples of the could not be determined	Hospital: 1 □ Inpatient 28e. Date of Injury (Month, Day Yee) 28e. Place of Injury -	2 ER/Outp r) 28b. Tir Inj At home, farm	natient 3 End of ury M. End of ury M. End of ury M. End of urgent in the courter of the cour	28c. Injur Wor 1 pry, office	26. Place of □ er: 4 □ Nursing y at k? Yes 2 □ No	24a. Was performed to the control of	en eutopsy med? /es 2 \(\) \	24b. Were euto available p completior of death? 1 Yes (Specify) or Rural Route	4 Unknown osy findings rior to of ceuse 2 No Number,
or Attending Physicien: The law requires that the cath therefor: After this certificate has been signed by the orbit timestor, page 2 should be detected in by the funeral director, page 2 should be detected.	To Be Completed by	25. Was cese referred to medicel examiner? 1 Yes	Hospital: 1 Inpatient 28e. Date of Injury (Month, Day Yee 28e. Place of Injury - building, etc. (Sp. relcian: To the best of my Inar: On the basis of exar- end manner stated.	2 ER/Outp r) 28b. Tir Inj At home, fam ecify) knowledge, inination and/	natient 3 to the control of the	28c. Injur Wor 1 Dory, office	26. Place of □ er: 4 □ Nursing y at k? Yes 2 □ No	24a. Was performed at the time,	en eutopsy med? fes 2 No 3 en eutopsy med? fes 2 No one) dence 6 Other now injury occurred Street end Number m, State) cause(s) and mann date and place, and	24b. Were euto available p completior of death? 1 Yes (Specify) di	4 Unknown bosy findings rior to of ceuse 2 No Number,
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					,	Certifica	ate of	Death		Reg. No.		(m)	
П	Dhorata	ł	1. Decedent's Name (First, Middle, Last	1)					2. Dete of Dec	eth		Time of Deeth	
	Physic /Medi		Charles Calvin MC	NAMEE					March	1 199	Yeer 9 1:	43 a.m.	
	Exami		4e. Fecility Name (If not institution, give	street end number)			4	b. City, Town, or	Location of Death				
			Avalon Manor Nursi	ing Home				Hagers	stown	Wash	ington		
	Funeral		Sociel Security Number		(In yrs. last bin	thday) If Unc	der 1 Year	If Under 24 Hrs Hours Min		h Yearl	9. Birthplace	Stete or Foreign	
	Director		215-18-2281 Usuet Residence of Decedent	ØM 2□F	74	Yrs.	- Cays	110013	Oct. 26		Maryla		
	ylen how		10e. State 10b. County		10c. City, Town	or Location					10d. In	side City Limits	
	Ma Miled	Director	Maryland Washing	gton	Hanco	ck					X	Yes 2 No	
	or 28	ire	10e. Street end Number			10f. 2	Zip Code			10g. Citizen of	Whet Country?		
	23a		119 W. Main Street	Ė			217	50		U.S	. A .		
21215-0020	dea rue	Funeral	11. Maritei Status	12. Wes Decedent Ev Armed Forces?	ver in U,S.	13. Wes Dec			Specify Yes or No- rto Rican, etc.)	14. Rac	e - American Inc	dien,	
	in 72 hours after death with the Maryland "netural", or items 23e or 28e-f show exical Exp. Wret. must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Y es, Give	W.W. II 42-45		2 X No		no mean, etc.,	Specify	ck, White, etc. V: Whit	e	
Ş	2 ho	Completed	15. Decedent's Edu	ucetion		Decedent's Us	suel Occup	etion		16b. Kind of B	usiness/Industry		
	C	ple	(Specify only highest gred Elementary/Secondary (0-12)	le completed) Coilege (1-4or 5+	,	(Give kind of I life. DO NOT	work done o	during most of wo	orking		,		
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9	be filed d other event,	Bec	17. Fether's Neme (First, Middle, Last)						me (First, Middle,				
la I	0 2 0 0	ToE	Paul E. C. McName	ee				Mary E	. Mowen				
Maryland	to DE		19a, Informent's Name/Reletionship (T)	vpe, Print)	19b.	Meiling Addre	ss (Street	end Number or R	Pural Route Numbe	r, City or Town,	State, Zip Code)	
	CHNF		Albert H. Bartles,	Sr.	66	8 High	land 1	Wav Hag	erstown,	Marvla	nd 2174	0	
e C	of Healt Item 2		20a. Method of Disposition		20b. Piece of	Disposition (A	ieme of	a)	Date		City or Town, S		
saitimore,	Pege nt: if ry of		1 Buriei 2 ☐ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)					metery	3/3/99	Hagerst	own, Ma	rvland	
	permit. Pages 1 Department of H Important: if its any injury or ot once.		21. Signature of Funeral Service Licens	ee .					nnich Fu			Lyland	
ñ	Deperiment of the service of the ser	١,	Scatte	2 Ch	(l. Hagers				
r			23a. Pert1. Enter the disease, or compl	ications that caused the	he death. Do n						-	oximete	
Ī	Physician /Medical		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Immediate Ceuse (Final										
	Examiner	Examiner	disease or condition resulting in deeth) e.								WK		
				0	Late	of -		2	22000				
	outex nemsi		Sequentietly list conditions. b. Ous Wuffue, Lung Disease Due to (or es e consequence of):							73			
Š	an al		Sequentietly list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or Injury							= 1.1.0			
00100	ntiticate be executed ng physician and ses the buriel-trensit	Medicai	thet initiated events resulting In death) Lest	Di	ue to (or as e c	onsequence of	1):				J.	\$	
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	0 0 0	Physician/	Part II. Other eignificant conditions cor	ntributing to death but	not resulting in	the underlying	ceuse give	en in Pert I.	23b. Did t	obacco use co	ntribute to the o	auee of death?	
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g		Bec	25. Wes cese referred to medical	11916 019				26 Place of De	ath (Check only o	- '			
>	Physician: this certific ral director,	ToE	examiner?	lospital:	2 ER/Out	petient 3 🗆 t	OOA Othe		Home 5 ☐ Resid		er (Specify)		
2	g Phy er thi		27. Menner of Deeth	28a. Dete of Injury (Month, Day)	28b. T	ime of	28c. Injury Work		28d. Describe h				
2	Attending ir death. actor: After by the fune	atio	1 Neturel 5 Pending 2 Accident investigation	(Mortin, Day)	rear) In	ijury M		Yes 2□No					
	or Attending efter death. Director: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			e Number,				
	To the Hospital or Attanding Physician: within 24 hours after death within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of a ner: On the basis of ea end menner state	xaminetion end	death occurre l/or investigetion	d et the tim on, in my op	ne, date end place pinion, deeth occ	e, end due to the curred et the time, c	euse(s) end me late end plece,	enner es steted. end due to the c	euse(s)	
	o the	ĕ Z	29b. Signeture end title of certifier			2	9c. License	number		29d. Date signed (Month, Dey, Yeer)			
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			20 Name and add				ע ד			7 ,	` ') /	' ' /	
			30. Name and eddress of person who co							0			
			Dr. Zafar Malik 31. Dete filed (Month, Dey, Year)			ns Roa	ad, E	Boonsbo	ro, MD	21713	3		
	Sta	te	MAR 0 9 10	32. Registrer's	Signature	4	1						



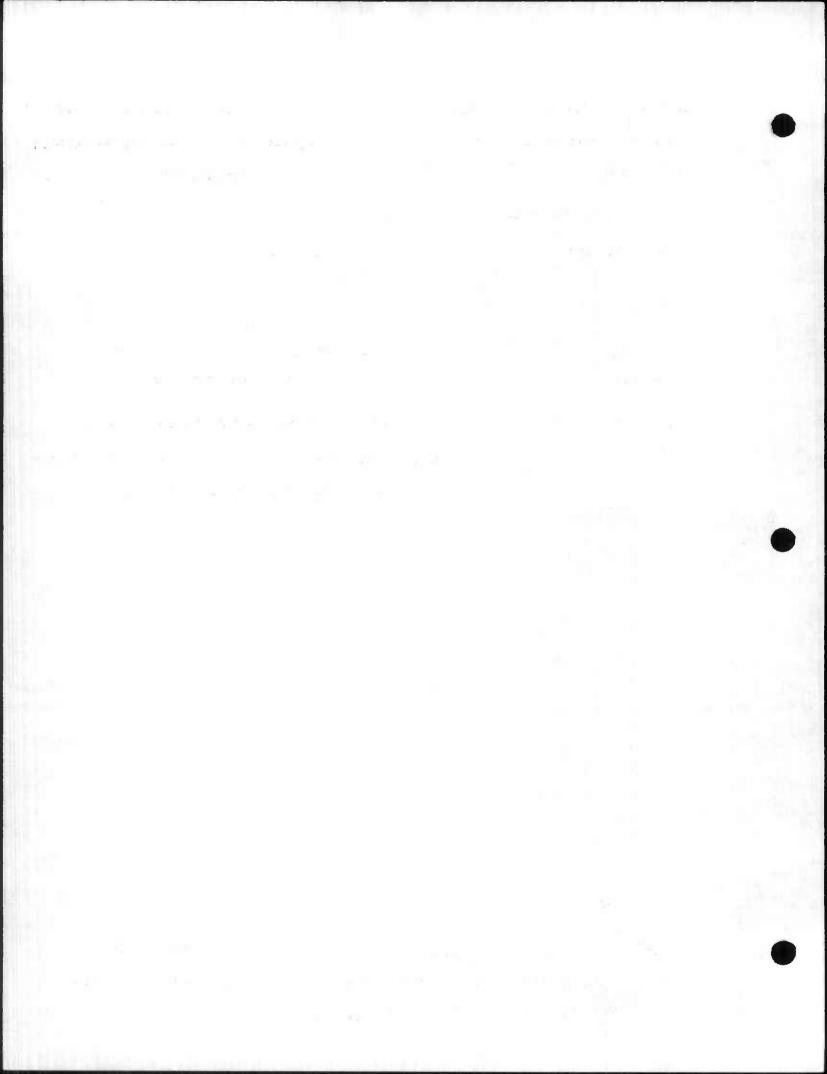
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month **Physician** LAURA MILDRED MANON February 26, 1999 9:10 PM /Medical 4a. Fecility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Washington County Hospital Washington County Hagerstown If Undar 1 Yaar | If Undar 24 Hrs. | 8, Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (Stata or Foreign Country) **Funeral** 1 M 2 XF 94 Yrs. Months 186-30-5602 Director Dec. 14,1904 Pennsylvania Usual Rasidance of Decedent 10a State 10c. City, Town or Location 10b County 10d. Insida City Limits the Maryla r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland WASHINGTON Co. Hagerstown 1 ☐ Yas 2 No Director 10e. Straef and Number 10f. Zip Code 10g. Citizan of What Country? 16905 Pickwick Lane 21740 USA Funera 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indien, Btack, Whita, atc. 11 Marital Status hours after 1 ☐ Yas 2 🕱 No If Yes, Give 1 □ Navar Marriad 2 □ Married Maryland 21215-0020 1 ☐ Yas 2 XNo Specify: White Specify. p 3 XWidowed 4 ☐ Divorced Year or Datas Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Hygiana. Elementary/Secondary (0-12) Collega (1-4or 5+) Recording Secretary 12 City Hospital 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 and 2 should be till ment of Health and Mental H lant. If Nem 27 is marked off Be George Knepper Agnes Kate Bumbaugh repartment of Health an important: If Item 27 is m any injury or other the Once. 19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) R. Eugene Manon/Son 1924 Winston Drive, Hagerstown, Maryland 21740 altimore, 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or othar place) 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Mar.2 Quincy, Pennsylvania 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licensee Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 23e. Tarti. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or raspiratory arrest, book, or heart felidira. List only one cause on each line. Approximeta Intervel Between Onsef and Deeth Physician /Medical Immediata Causa (Finai Hypertensive Cardio Vascular Disease vears disease or condition rasulting in deeth) Examiner Dua to (or as a consequence of): Examiner and Parkinsons Disease vears Sequentielly list conditions, if eny, laading to immadiata ceusa. Entar UnderlyIng Cause (Disaasa or Injury that initiatad avants rasulting In daeth) Last physician and the burial-tran Dua to (or as e consequence of): cartificata be axecu P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): USB BS attanding p ata has been signed by tha e page 2 should be datached i Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Right Intertrochanteric Hip Fracture Records. þ 24b. Wara autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yas 2X No 1 □ Vas 2 □ No certificata Division of Vital Be 25. Was cesa rafarred to medicel 26. Placa of Deeth (Check only ona) axaminar? Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) Hospitai: 1 XXopafient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 X Yas 2 No this funarai 27. Mannar of Deeth 28e. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Aftar 5 Panding Injury 1 Natural death. 1 Yas 2 No Fell trying to get out of bed 7:00 AM e Hospital or Attendi n 24 hours after death e Funeral Director; A invastigation February 22, 1999 2 X Accident 6 Could not be determined 3 ☐ Sulcida 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify)

AT Home 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) in by 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di complataly filled in 1690 Pickwick Lane Hagerstown 1 Cartifying Physician: To tha best of my knowledga, daath occurred at the time, dete end piece, end dua to tha causa(s) and menner as steted.

2XXMedicaf Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, data and piace, end dua to the ceuse(s) and mannar stated. edicai 29a. Certifiar 29b. Signatura and tale of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) D. Hear DO1062 March 1, 1999 30. Nama and address of person who complated ceusa of daath (Itam 23a) Ptype, Print) M.D. 217 W. WASHINGTON ST. Edward W. Ditto, III, HAGERSTOWN, MD 21740 32. Regisfrer's Signatura 31. Data filed (Month, Day, Year) State MAR 02 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Beatrice Theresa McCarter /Medical 4e Facility Neme (II not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital McCarter, Beatme If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 M 2 F Months 201-24-9176 67 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Directo Maryland

4c. County of Death Hagerstown Washington If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 25, 1931 Birthplece (State or Foreign Country) Pennsylvania

Reg. No.

2. Dete of Deeth Month

ebruar

Washington Smithsburg

10d. Inside City Limits 1 ☐ Yes 2 🖾 No 10f. Zip Code 10a. Citizen of Whet Country?

10e Street and Number 12005 Holiday Circle 12. Wes Decedent Ever in U.S. Armed Forces? 11 Meritel Status

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2₺ No Specify:

21783

Bleck, White, etc. Specify: white

14. Race - American Indien.

USA

1 Yes 2 No
If Yes, Give
Year or Detes: 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

her own home

17 Father's Neme /First Middle Last

1 Never Married 2 X Merried

3 ☐ Widowed 4 ☐ Divorced

or harna 23a or

Department of Health and Schould be filed Department of Health and Mental Hygo Important: If them 27 is marked other way injury or other recognition

Physician

/Medical Examiner

and

physician at the burial

by

Completed

Be

To

Certification:

edicai

this

ne Hospital or Attending Ph n 24 hours after death. The Funeral Director: After the

To the Hospital of within 24 hours at To the Funeral D

Box 68760.

P.O.

Records,

Division of Vital

Baitimore, Maryland 21215-0020

the Medical Examiner must be

þ

Completed

88

18. Mother's Neme (First, Middle, Meiden Sumeme) Jennie Lovendusky

William Borum 19e. Informent's Neme/Reletionship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12005 Holiday Circle, Smithsburg, Md. 21783

Stanley M. McCarter - husband 20e. Method of Disposition

20b. Plece of Disposition (Name of cemetery, cremetory or other plece)

20c. Location - City or Town, Stete 3-1-99 Hagerstown, Maryland

1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fuperal Service Licenses

Cedar Lawn Mem. Park 22. Neme end Address of Facility

MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

4:32

Immediate Cause (Finel disease or condition resulting in death)

Due to (or as e consequence of

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Physician/Medical

estrue

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

mellitus

24e. Wes en eutopsy

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 X Yes 2 No

28d. Describe how injury occurred

L. COPPECES

1 ☐ Yes 2 No

25. Was case referred to/medical examiner? 1 ☐ Yes 28 No

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Menner of Death Neturel 2 Accident 3 Suicide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28c. Injury at Work? 1 Yes 2 No Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner es stated.

Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated.

29c. License number

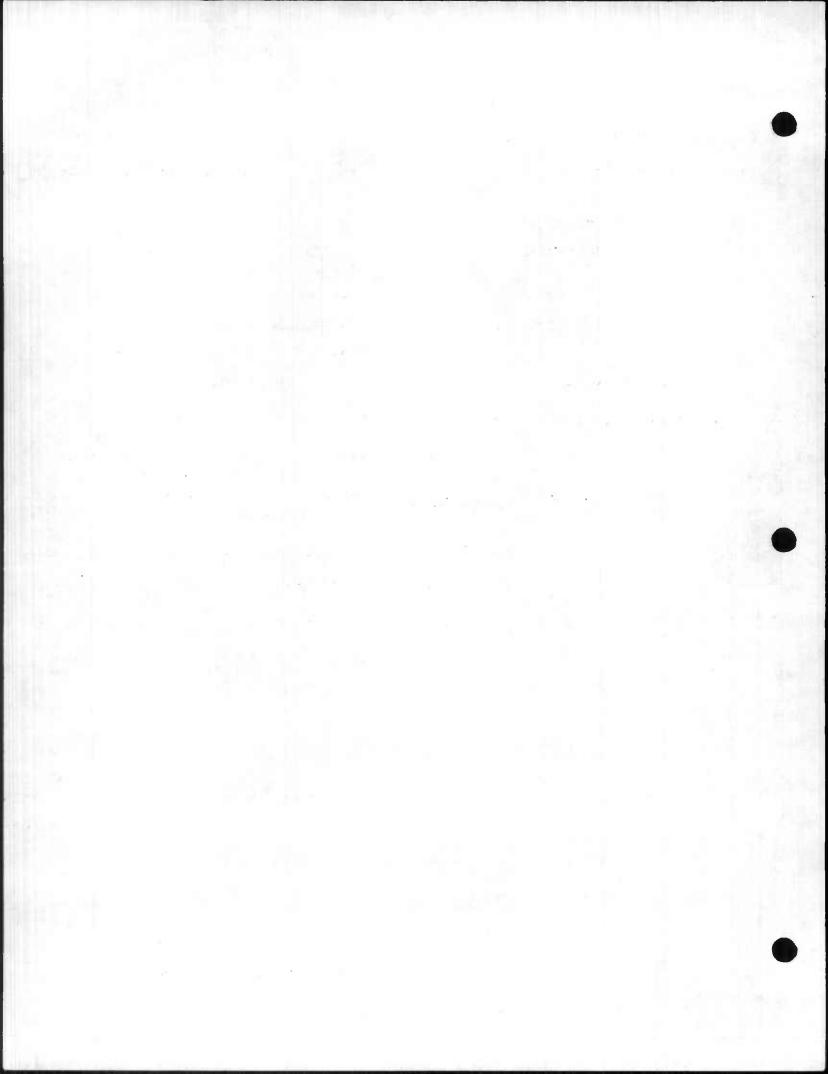
29b. Signature and title of certifier

, chil). 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Dey, Year)

State Registrar

31. Date filed (Month, Day, Year) **FEB 2 6**

Hagersfown Will St 32. Registrar's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Deeth Month 1999 10:20 AM Myers Feb 28 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth WAlkersville Glade Valley Nursing + Rehab Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Add to the control of the Frederick 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) 1 M 2 F 92 2/8 03 3233 Usuel Residence of Decedent Yrs 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD WESTMINSTE 1 Pres 2 No ARROLL 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? USA 21157 10 WINCHESTER AVENUE 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2□No Specity: WHITE Specify 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) GROCER Elementary/Secondary (0-12) MEAT CUTTER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) EDWARD . MYERS ORA 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionskip (Type, Print) LINDA NULL NIECE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition 3/99 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility PRIHS FUNERAL HOME & Chapel of Funerel Service Licenses 412 WASHINGTON EOAD WESTMINSHEE, MARYLAND 21157 Lanier the mode of dvind. Such as cerdiac or respiretory errest, nter the disease, or complications that ceused an dear heert feilure. List only one ceuse on eech limit Approximete Interval Between Onset end Deeth Immediete Cause (Final diseese or condition resulting in death) 2aRS Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 10 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of ceuse of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth

Physician /Medical Examiner

the

signed by

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page 2 hes

director,

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certificete

After this funeral

24 hours efter death. Funeral Director: Al

within 2 To the

or Attending Physicien:

Hospital

certificate be executed attending physicien and for use as the buriel-trent

Division of Vital Records, P.O. Box 68760

any injury or o

Physician

/Medical

Examiner

10e. Stete

Director

Funeral

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Completed

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Examiner

Physician/Medicai

A

Completed

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Certification:

Medical

State Registrar

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Examinar must be notified at

permit. Pages 1 end 2 should be filed within 72 hours after death bepartment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23.

altimore, Maryland 21215-0020

with the Merylend

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury Ihel initiated events resulting in death) Last

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes cese referred to medical exeminer?

5 Pending investigation

28e. Date of Injury (Month, Dey Year)

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2□No 28d. Describe how injury occurred

FRED

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifie (Check only one)

1 Adatural

2 Accident

4 Homicide

3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner stated.

29c. License number

29d. Dete signed (Month, Dey, Year)

mpleted ceuse of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, ferm, streef, fectory, office building, etc. (Specify)

21702

Date filed (Month, Dey, Yeer)

32. Registrer's Signature

MAR 0 2 1999

6 Could not be determined

DHMH 16 Rev 6/95

LIB CHECKLE VISITINGEL . . . Of Whitehest Edward Aug 3 ... 1-1-1 10 mm E. M. Carlotte Carlotte Live , hid while Sign or Estimate in the Me and the second second

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Deeth Yaar **Physician** Stewart 7:30 p.m. Harlan Mycrs te 1999 24 /Medical 4a. Facility Nama (If not institution, give street and number)
1409 Pleasant Va 4b. City. Town, or Location of Death 4c. County of Death Examiner Westminster Valley (0)
7. Aga (In yrs last birthday) Model If Under 1 Year nrrol If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 9. Birthplaca (Stata or Foraign **Funeral** 12M 2□F Months Days 216-14-580. Usual Rasidance of Decedant Yrs Director T. 20, 1920 10a. Stata 10b 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at estminste 1 Yas 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizan of What Country? ò permit. Pagas 1 and 2 should be filed within 72 hours eftar death v Department of Haaith and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a say hijury or other traumatic event, the Mexical Examiner mans once. 1409 Valley 211 Noad Funeral 12. Was Decedant Evar In U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status I ZYas 2 No It Yas, Giva Yaar or Datas: [? 52 - 72. 1 Nevar Married 2 Married 1 ☐ Yas 2 ₺ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DQ NOT use retired) 15. Decedant's Education (Specify only highast grada compiated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) chinisi 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Meidan Sumama) Be To avia German ura 19a. Intorment's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Rd. Betty A 20a. Mathod of Disposition Westminster MD. 21158
20c. Location - City or Town, Stata ers, wite Valley 20b. Place of Disposition (Nama of cematary, cramatory or other place) Date 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Pleasant Valley Cemetery 2-27-99 Westminster, MD.

22. Nama and Address of Facility Prints tuneral Home & Chapel, P.A.

412 Washing Ton Ed.

Westminster, MD. 21157

Enter the disease, or complications that caused the chain. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Approximate

Interval Rehuser. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Sepature of Funarai Sarvice Licensea Approximata Intarval Batween Onset and Death Physiclan /Medical Immediata Causa (Final irahosis HEPATIC 2 YEAR disease or condition rasulting in deeth) Examiner Due to (or as a consequence of) Examiner physician and the buriel-transit Saquentially list conditions, if any, laading to immadiata ceuse. Entar Undarfying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): 98 for usa signed by the a d be dateched f Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? CORONARY ARTERY Disease 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Ware autopsy tindings availabla prior to completion of cause of death? 24a. Was an autopsy periormed? page 2 s 2 No cartificate 1 ☐ Yas 1 ☐ Yas 2 ☐ No tha funaral director, Be 25. Was casa ratarred to medical axaminar? 28. Place of Deeth (Check only one) Hospital: Othar: 4☐ Nursing Homa 5 1 Rasidence 6 ☐ Othar (Specify) Medical Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Panding invastigation 1 Naturel within 24 hours after death. To the Funeral Director: A 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, straat, tactory, office building, etc. (Specify) completaly filled in by 4 Homicida 29a. Certifier 11 Contifying Physician: To the best of my knowledge, death occurred at tha time, date end piece, end due to tha causa(s) and manner as steted. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be axecuted Records, P.O. Box 68760. Division of Vital Hospitai ŝ

with the Meryland

Baltimore, Maryland 21215-0020

State Registrar

DAIVW MD HOMAS 31. Data filed (Month, Day, Year)

ma

29b. Signatura and title of certifian



TOLV W

295 STON BR

29c. Licensa number

D31660

Avenue

29d. Data signed (Month, Dey, Year)

WESTMINSTER mo

21157

MAR 0

30. Nama and address of person who complated ceusa of daath (Itam 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** FEB Laine Philip Moore /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs.

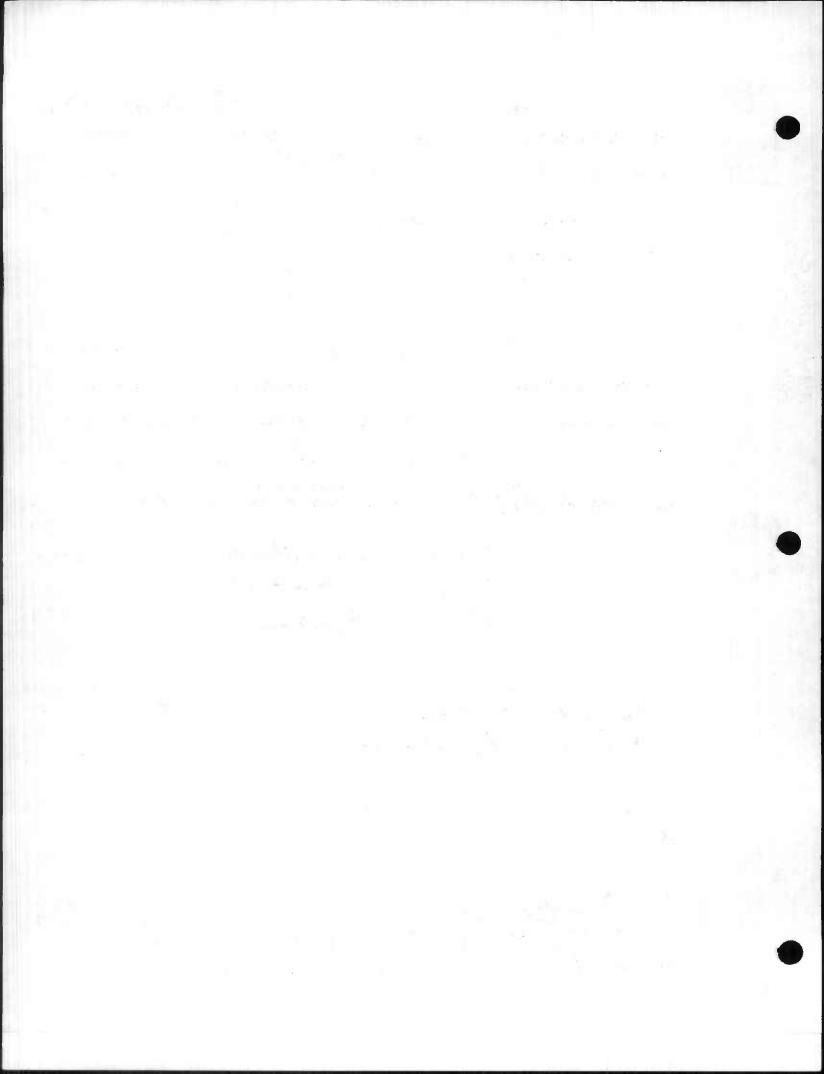
Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 1XM 2□ F Director 214-53-5283 6 Aug. 6, 1998 Maryland Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tra Madical Examinar must be mailfied at 1 ☐ Yes 2 No Director MD Wicomico Delmar 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 8780 Wood Creek Parkway 21875 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Introcremit: If item 27 is marked other than "natural", or iter any injury or other traumatic event, tra Medical Process 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Dacadant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilaga (1-4or 5+) Never Worked Never Worked 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Kenneth Norman Moore, Jr. Patricia Estelle Briles Moore 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Streat end Numbar or Rural Route Number, City or Town, Stata, Zip Coda) Kenneth N. Moore, Jr./ Father 8780 Wood Creek Parkway Delmar, MD 21875 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) |3-3-99|Stephens Cemetery Delmar, Delaware 21. Signeture of Funeral Service Licanses 22. Name end Address of Fecility Short Funeral Home 13 E. Grove St. Delmar, DE 23e. Pert1. Enter the disease, or complications that shock, or heart feilure. List only one cause or the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximate Intervel Betwean Onset end Deeth Physician /Medical Immediate Ceusa (Final diseese or condition rasulting In daeth) **Examiner** Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that initieled events resulting In daeth) Lest end Dua te (or es e consequença of) physician er s the buriel-t Physician/Medical Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Congestine Heart Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown by Inonony Hypertension 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy parformed? Completed page 2 s hes 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No · Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certifica etely filled in by the funeral director, 25. Wes case referred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 DOA 27. Mannar of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Netural 2 Accident 5 Pending Investigation 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 | Homicida To the Hospital o within 24 hours eff To the Funeral Di completely filled in Certifying Phyeician: To the best of my knowledga, deeth occurred et the tima, deta end place, end due to tha ceusa(s) end mennar es steted.

Medical Exemine: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) and menner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Yeer) 29b. Signature endotte of certific and address of portun who complated causa of daath (Item 23e) (Type, Print) 30. Nan 1085R STEPHEN 31. Dete filed (Month, Day, Yaar) 32. Registrar's Signetura State 1999 MAR 01 Registrar

Baltimore, Maryland 2121

P.O. Box 68760

Division of Vital Records,



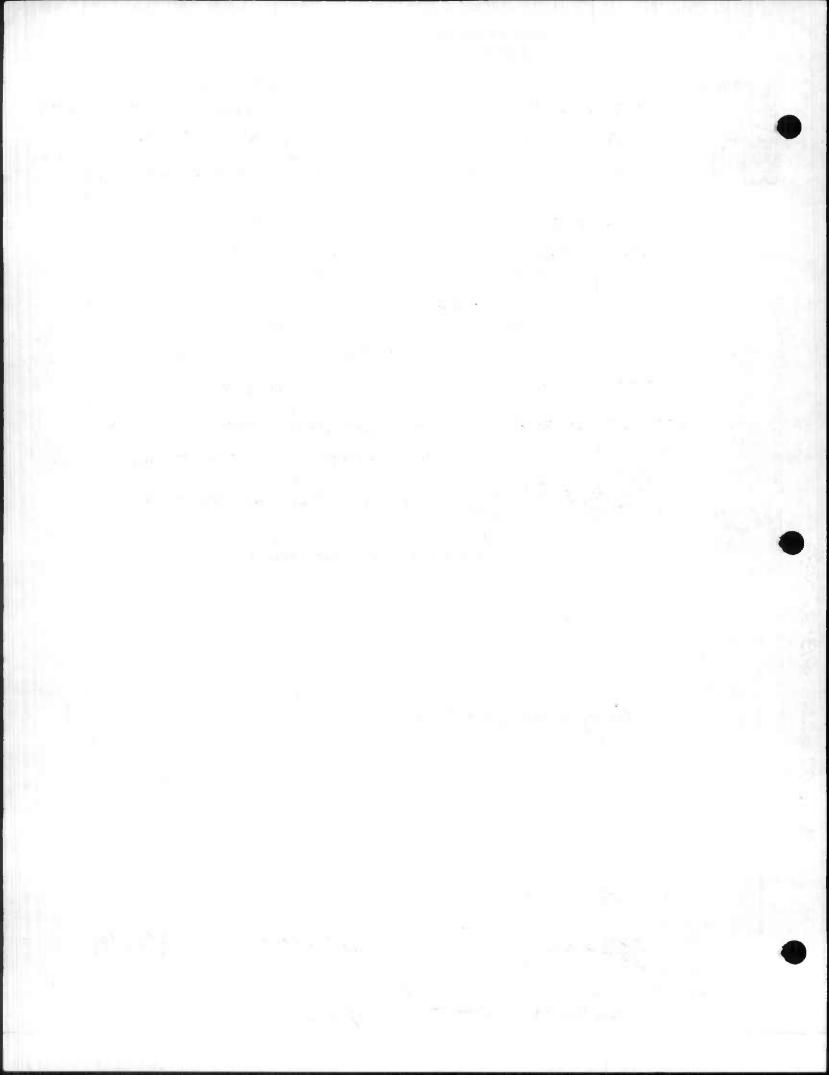
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 9 9 0 8 | 3 3

				Cerunc	ale or	Deam		Reg. No.		
Physician /Medical		MAS MORRIS					2. Dete of D Month February	ARY 251	Year 999	1540
Examiner	4a. Fecility Neme (If not institution, give street end number) PENINSULA REGIONAL MEDICAL CENTER						or Location of Dea	4c. County of Death WICOMICO		
Funeral Director	5. Sociel Security Number 213–22–7535	6. Sex 1X M 2□ F	Age (In yrs. last	birthday) If U	ths Days	If Under 24 H	in. (Month, E	irth ay, Year) 8, 1929	9. Birthplace (Country) MARYLAN	State or Foreig
the Maryland 28a-f show notilied at	Usuel Residence of Decedent 10a. State 10b. Cour MD WICO			own or Location						slde City Llmit
oth with the Maryle 23a or 28a-f ahoust be notified at ral Director	10e. Street and Number	1100	WILL		Zip Code			10g. Citizen of	What Country?	
eth wings	6753 BENT PINE				21874			USĄ		
be filed within 72 hours efter deeth with the Maryland tal Hygiene. d other than "netural", or items 23e or 28e-f show event, the Medical Exeminer must be notified at the Completed by Funeral Director.	11. Marital Status 1 Never Married 2 M M 3 Widowed 4 Divorce	If Yes, Give	☐ No		ecedent of H specify Cuba s 2X No		(Specify Yes or Nerto Rican, etc.)	o- 14. Rac Ble Specifi	ca - American Inc ck, White, etc. WHITE	lian,
led within 72 hours bygiene. The Medical Eve Completed by	15. Deced (Specify only hig Elementary/Secondary (0-12	lent's Education hest grede completed) College (1-4)	or 5+)	6a. Decedent's I (Give kind o life. DO NO	Jsuel Occup work done Tuse retired	pation du <i>ring</i> most of w d)	vorking	16b. Kind of B	usiness/industry	
be filed withintal Hygiene. d other than event, the M	6		1	HORSE EX	KERCIS				RACING	
d 2 should be filed th and Mental Hygie T is marked other traumatic event, II	17. Father's Name (First, Middle CHARLES B.	MORRIS					lame (First, Middl L THOMAS	e, Maiden Sumen	10)	
permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau	19a. Informant's Name/Relation ANITA M. MORR 20a. Method of Disposition 1	IS, WIFE n 3 □Removal from Sta (Specify)	20b. Plece	6753 BI of Disposition etery, crematory HOPE CE	ENT PI (Name of or other place METERY	NE ROAD	WILLAR Date	DS, MD	21874 City or Town, S	,
Physician /Medical Examiner	23a. Pell. Enter the disease, shock, or heart failure. L' Immediate Cause (Final disease or condition resulting in death)	or complications that obe ist only one cause or man	Belaker	o not enter the	mode of dyir	ng, such es card			Appr	oximate val Between et end Death
or certificate be executed shifting physician end use as the buriel-transit in/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last	b c		a consequence						
d by the etteretached for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause					en in Part I.	23b. Did	I tobacco use co	ntribute to the o	aves of deat
or Attanding Physiolen: The law requires that the deatt safer death. Director: After this certificate hes been signed by the ette in by the funeral director, page 2 should be detached for ertification: To Be Completed by Physicia	ph of	Multyp	u ev	A's			10	Yes 2□ No	3 Probably	Unkno
aw requires been size should pieted								s an autopsy ormed?	24b. Were eu eveilable completi of deeth	prior to on of cause
							1 🗆	Yes No	1 🗆 Yes	No No
Physicien: The ribis certificate arel director, peg	25. Was case referred to medi examiner?	Hospital:			Oth	OF.	eeth (Check only			
After fune	Inpatient 2LIER/Outpetient 3LI DC					DA Survey 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No				
To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After completely filled in by the funer. Medical Certification:	Solicide 3 Suicide 4 Homicide 4 Homicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Ru. City or Town, Stete)							per or Rural Rout	e Number,	
he Hosp in 24 hou he Funei pletely fill edical	29a. Certifier (Check only one) Certify	ring Physicien: To the be al Examiner: On the basis and manner	s of exeminetion	ige, death occur and/or investige	red et the tin tion, in my o	ne, date end pla pinion, deeth oc	ice, end due to the courred at the time	ceuse(s) end ma , dete and place,	anner es stated. end due to the c	ause(s)
with To the	29b. Signeture end title of carti	fier Klen			29c. Licens		5		d (Month, Day,)	ear)
3-+1VA	30. Name en address of person	on who completed cause on J. Hudo	. 1 1	a) (Type, Print) M. D	•	106 m	stuford.	st. Si	dis buri	, md.
State	31. Date filed (Month, Day, Yes		istrar's Signeture		1		2			1)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey Yee Helen Yingling Neudecker Feb 26, 1999 10::20 pm 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Long View Nursing Home Manchester Carroll If Under 1 Yeer 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days Months Hours 1 M &F F 216-03-9805 Yrs 80 Oct 22,1918 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll Hampstead 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1433 Fairmount Road 21074 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. I ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1□ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Black & Decker Shipping & Receiving 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Harvey C. Yingling Lillie Armacost 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert Yingling, brother 3024 Wertz Ave, Manchester, Md 21102 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) New Lutheran Cemetery 3/2 Manchester, MD 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee Eline Funeral Home tu 934 South Main St, Hampstead, MD 21074 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel diseese or condition resulting in deeth) ww comin Due to (or es e and equence of): Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting In deeth) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 10 Tes 2 No 3 Probably 4 □ Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 ₩NO 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 2 100 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of

Physiclan /Medical Examiner

that the deeth certificate be executed

The law

or Attending Physician:

Hospitai

Box 68760.

P.O.

Records, requires

of Vital

Division

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-1 show

ral', or Items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter or Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Itel any Injury or other traumatic event, the Medical Evantmen

Baltimore, Maryland 21215-0020

Directo

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Examiner buriai-trensit physician the buna Physician/Medical es esn signed by the e þ Completed should page 2 has certificate director, Be Certification: To this funeral After 24 hours efter death. Funeral Director: A the

1 Yes 27. Manner of Deeth Naturel

29a. Certifier

(Check only

31. Dete filed (Month, Dey, Year)

25. Wes cese referred to medical

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Date of Injury (Month, Dey Yeer)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Location (Street end Number or Rurel Route Number, City or Town, State)

29b. Signature a

29c. License number 165

🖅 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as steted.

2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. 29d. Date signed (Month, Dey, Year)

30. Name and add s of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

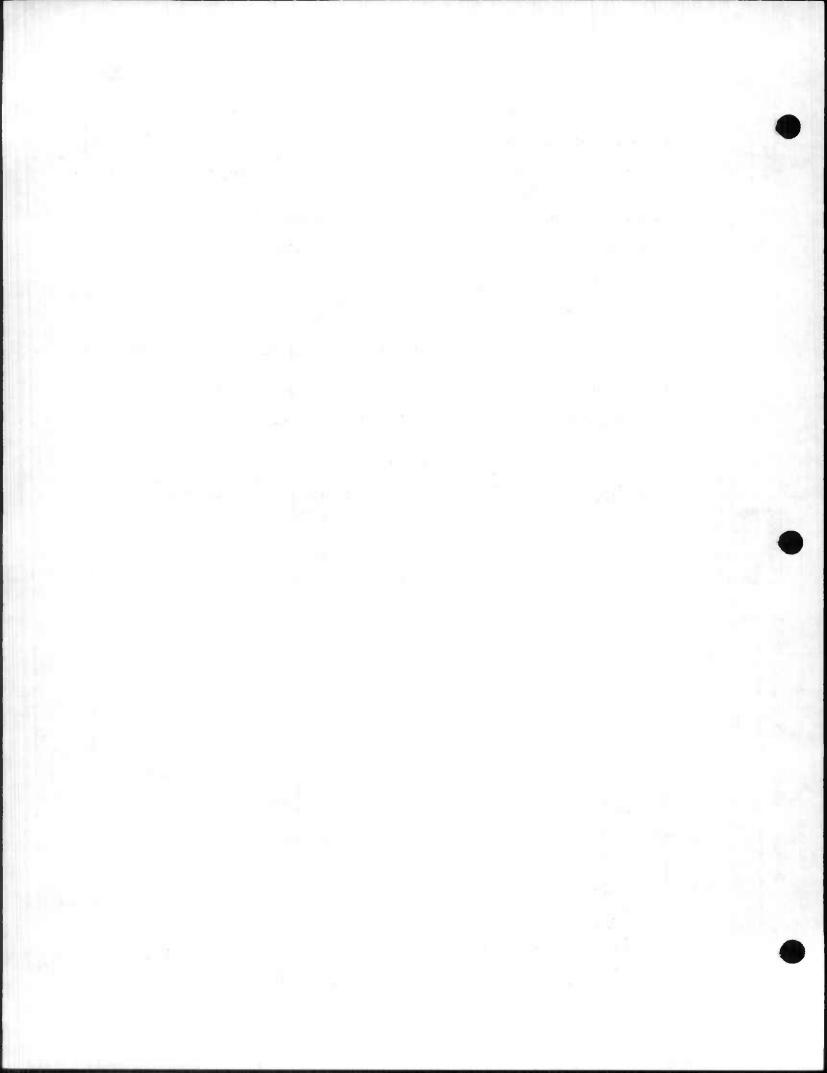
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Medical

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32. Registrer's Signeture



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State of Maryland / Department of Health and Mental Hygiene

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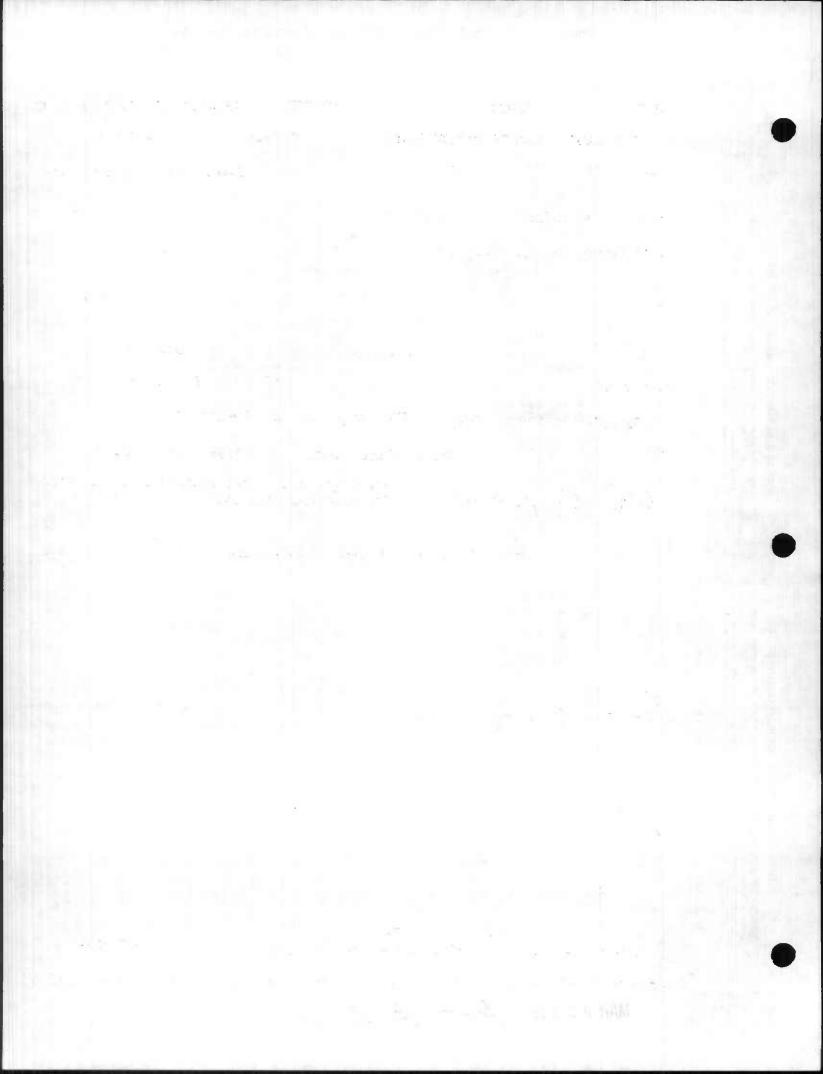
Certificate of Death 1. Decedent's Nama (First, Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** OVERTON JOHN. **FEBRUARY** 27 1999 LEROY 1:10 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner WORCESTER BERLIN BERLIN NURSING & REHABILITATION CENTER 5. Social Sacurity Number If Under 1 Year 8. Dete of Birth (Month, Dey, Yeer) 7. Aga (In vrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 XM 2 □ F Months Hours 93 214-32-0349 June 10,1905 Director North Carolina Usual Rasidence of Decedant with the Merylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at TX Yas 2 No Salisbury Maryland Wicomico Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21801 USA 1514 Riverside Dr., Apt. C214 Funeral death permit. Peges 1 and 2 should be filled within 72 hours after deat Depertment of Heelth end Mental Hygiene. Important: If item 27 is marked other than "seno they traumed. 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Giva Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 Tes 2 No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Salesman Insurance 12 18 Mother's Name (First Middle Meiden Sumeme) 17. Fathar's Neme (First, Middle, Last) (unknown) Effie John Overton 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 174 Sandy Hook Rd., Berlin, MD 21811 Betty Lynne Arvin/Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State 3/1/99 Quantico, MD St. Phillips Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funarei Seprice Licensee 22. Name end Address of Fecility Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complete tions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errast, shock, or heart feiture. List only she cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximete Intervel Between Onsat and Deeth **Physician** lie Carlinasculas /Medical Immadiata Causa (Final diseese or condition resulting in death) Examiner Examiner bunial-transit requires that the death certificete be executed Bud Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in death) Lest Due to (or es e consequence of): O. Box 68760 physician Physician/Medical the Dua to (or as e consequence of): 88 attending o ed by the a detached f Pert ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy peen page 2 has 1 □ Yas X No 1 ☐ Yes 2 No certificate or Attending Physician: effer death. Director: After this certific funeral director, 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4X Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 🗆 No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) completely filled in by 4 | Homicide • Hospital 124 hours e • Funeral D 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner stated. 29a. Certifier Medical To the To the To the I 29d. Data signad (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number egern Meme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR., SALISBURY, MD. 21801 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

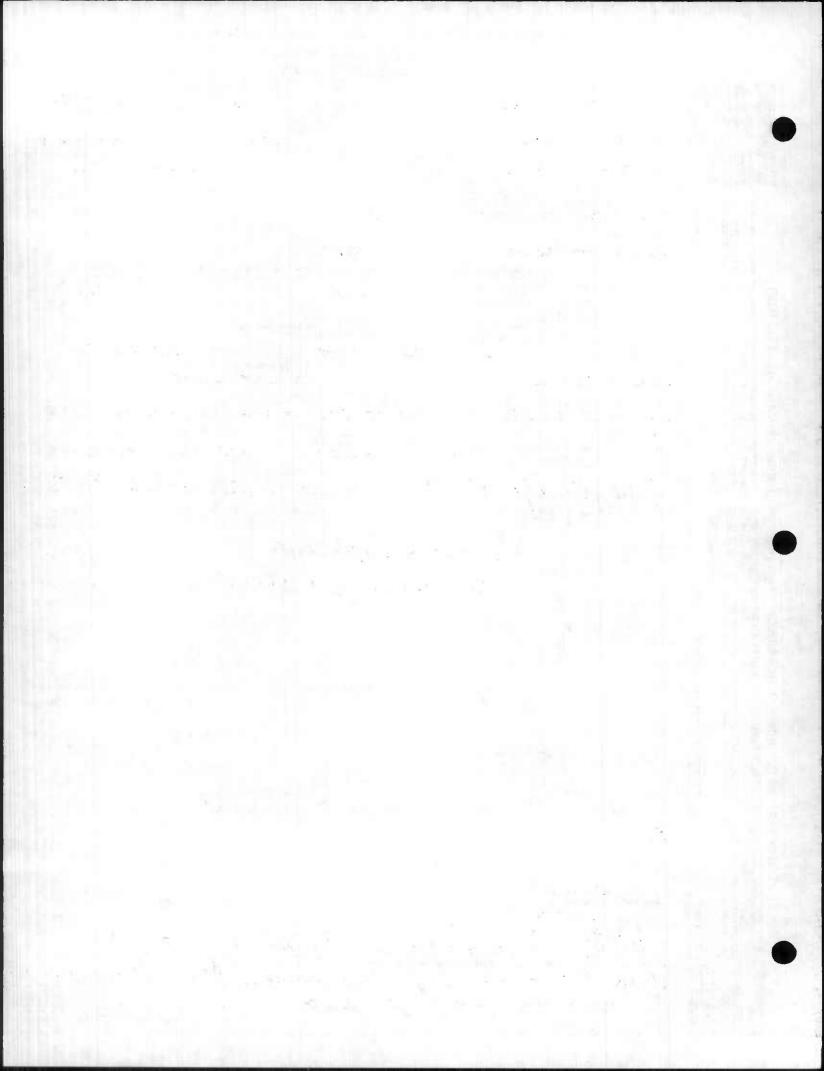
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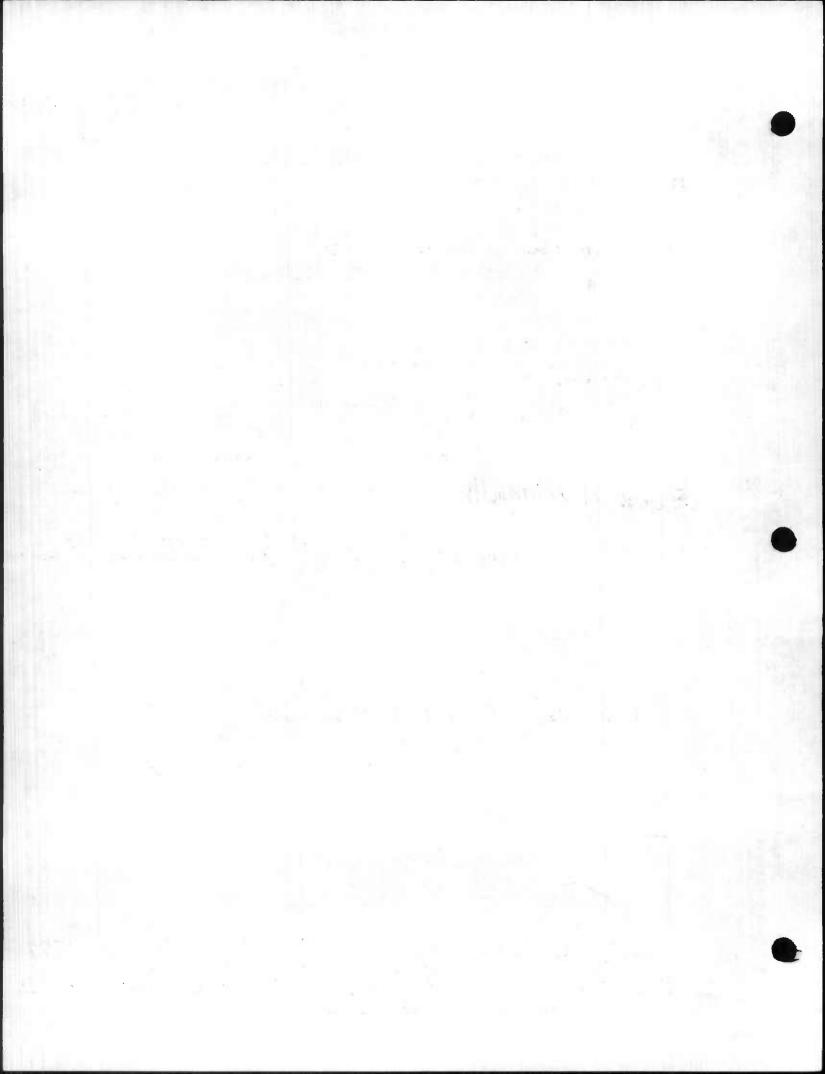
State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 02 Eugene Carroll Pfeffer 1999 /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 908 West Irvin Avenue Hagerstown Washington County If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** 158 M 2 . F Months Deys 67 218-28-3566 Maryland Director 23, 1931 Usuel Residenca of Decedent the Marylen 10c. City. Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or frems 23s or 28s-f show traumstic event, the Madical Examiner must be notified at Maryland Washington County Hagerstown 1X Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 908 West Irvin Avenue 21742 USA Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Meritel Status 1 ☐ Nevar Merried 2 ☐ Merried White Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Tool Engineer Helicopter Mfg. 0 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Herman J. Pfeffer Catherine M. Helm 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code, 19a. Intormant's Name/Relationship (Typa, Print) 908 West Irvin Avenue, Hagerstown, Maryland 21742 Marie A. Pfeffer/Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mar.5 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) ^{22. Neme end Address of Fecility} Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 21. Signature of Funeral Services icanses 23a. Port1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only one cause on each line. Approximete Intervel Betweer on at and Deat **Physician** /Medical Immediate Ceuse (Final -oun diseasa or condition resulting in deeth) Examiner Examiner =15ENMENGEN physician and the buriel-trans Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or as a consequence ot) requires that the death certificate be exec Box 68760, ettending physician Physician/Medical Due to (or as e consequence of): USB BS Pot signed by the e 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy tindings aveilable prior to complation of cause of deeth? 24e. Wes an autopsy peen page 2 has 2000 1 ☐ Yes 2 ☐ No 1 Yes certificate or Attending Physician: funeral director, Be 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Homa 5 Aesidence 6 Other (Specify) 10 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 20 No After this 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Naturel 5 Pending efter deeth. 1 Yes 2 No investigation 6 Could not be determined 28t. Location (Street end Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homlcide Hospital 24 hours 29a. Certifie Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted. Medical completely 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. (Check only one) within 2 \$ 29d. Date signed (Month, Day, Year) 29b. Signat HYSIC 17 impleted cause of death (Item 23e) (Type, Print) MAR 0 32. Augustuur's Signeture State 1999 Registrar

DHMH 16 Rav 6/95



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	Certificate of Death	R	eg. No. 99 U8137				
	Decedent's Neme (First, Middle, Last)	2. Date of Deat	h 3. Time of Death				
Physician /Medical	Harold Enos Peters	Feb.	24 1999 3:00p. N				
Examiner		wn, or Location of Death	4c. County of Deeth				
		erstown	Washington				
Funeral Director	5. Social Security Number 220-30-7564 6. Sex 1.2 M 2 F 94 7s. F 1.2 M 2 F 94 F 1.2 M 2 F 24 M 2 F 3 M 2 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3 M 2 F 3	24 Hrs. 8. Date of Birth (Month, Day, April 6,	9. Birthplace (State or Foreign Country) 0010				
2 .	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location		101111111111111111111111111111111111111				
o Maryta talled at ctor	Maryland Washington Williamsport		10d. Inside City Limits 1 ☐ Yes ※☐ No				
death with the Maryti rms 22e or 28e-1 sho if must be notified at neral Director	10e. Street and Number 10f. Zip Code 16505 Virginia Avenue Cottage 112 21795	11	0g. Citizen of What Country? USA				
st, or the Examine by Fu	11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Merried 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Specify: 1 Yes, specify Cuban, Mexican 1 Yes 2 No Specify:		14. Race - American Indien, Bleck, White, etc. Specify: White				
72 ho	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during mos	et of working	16b. Kind of Business/Industry				
ed within 72 ho systems. her than "neturn rt, the Medical. Completed	Elementery/Secondary (0-12) College (1-4or 5+) 4 General Secretary	or working	Y. M. C. A.				
	17. Fether's Neme (First, Middle, Last) 18. Mothe	er's Name (First, Middle, A					
uld be it Mental H riked off file ever		ie Rogers					
nd 2 shor alth and h 27 is ma r trauma	19a. Informent's Neme/Reletionship (Type, Print) Virginia K. Peters Wife 16505 Virginia Ave	er or Rural Route Number. ., Cottage 1	, City or Town, State, Zip Code) 12 Williamsport, Md. 2179				
Pages 1 a nent of He rst: If Nem rry or othe	20e. Method of Disposition 1 Burial 2 Stremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cametery, cremetory or other place) 5 Smithsburg Crematory 20c. Location - City or cametery, crematory 2/25/99 Smithsburg,						
Departm Departm Imports any Inju	21. Signeture of Funerel Service Licensee 22. Name and Address of Facility	ty 305 N	Potomac Stroot				
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as shock, or heart failure. List only one ceuse on each line.	Hagers	town, Maryland 21740				
death certificate be executed estending physician and by for use as the bunal-transit sician/Medical Examiner	Due to (or as e consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of):						
ath certification of the use as for use as	d						
	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I		23b. Did tobacco use contribute to the cause of death				
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The law requires to the law requires to page 2 should be Completed by		1 🗆 Ye	es 2 No 1 Yes 2 No				
certificate rector, pag	25. Was case referred to medical exeminer?	e of Death (Check only on	(9)				
T T	1 Yes 2 JAK Hospitel: 1 Thipatient 2 ER/Outpatient 3 DOA Other: 4 Nu		ence 6 Other (Specify)				
eath. or: After th the funeral cation:	27. Menner of Seath 1 Product 5 Pending 28a. Dete of Injury 28b. Time of Injury at Work?		ow injury occurred				
at or Attending P at a star death. In Director: After the funer of in by the funer Certification:	2 Accident investigation 3 Suicide 4 Homicide M 1 Yes 2 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)		reet and Number or Rurel Route Number, n, Stete)				
To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Medical Certific	29e. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date an Check only Chec	d place, and due to the cuth occurred at the time, d	ause(s) end manner as steted. ate end place, and due to the ceuse(s)				
the thin 2 the maple of the Med	end menner steted.						
To Too	29b. Signeture end title of certifier 29c. License number	11250	9d. Date signed (Month, Dey, Year)				
10	30 Name and offices of more of myse cion	7337	reb 15 1999				
3. 8	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Brul MD 1459 Botowec Ave	e. Hage	rstown 2/742				
State Registrar	31. Date filed (Month, Dey, Year) FFB 2 6 1999 32. Registrer's Signature	V					



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State of Maryland / Department of Health and Mental Hygiene

			A Donate No. No. of Control of the C			rtificate of	Death	R	eg. No.	UU	156				
Physic		ian	1. Decedent's Neme (First, Middle, Last)					2. Date of Deet Month	th Day	Dey Year 8					
6	/Medi		ELIZABETH WILLIAMS PURNELL				4b. City, Town, or Location of D				8:10 AM				
	Exami	ner 	33098 Johnson F				Salisbu		4c. County Wico	mico					
	Funeral Director		5. Sociel Security Number 6. Se 220-12-1483	7. Age (/n	yrs. lest birthdey) Yrs.	If Under 1 Yea Months Deys		8. Dete of Birth (Month, Dev. 6/8/07	Year)	9. Birthpiece Country)	(Stete or Foreign				
21215-0020	Maryland	tor	10e. Stete 10b. County Worces		c. City, Town or Lo Berlin						inside City Limits 1 No 2 No				
	th with the 23a or 28a	Funeral Director	10e. Street end Number 101 Washington	St.		10f. Zip Code 218	11	10	0g. Citizen of W	Whet Country?					
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	within ene.	Completed	15. Decedent's Edi (Specify only highest gred Elementery/Secondary (0-12)	(Specify only highest grede completed)		16a. Decedent's Usuai Occupation (Give kind of work done during most of work life. DO NOT use retired) Nursing		rking 16b. Kind of Busi							
p	H the	BeC	17. Father's Neme (First, Middle, Last)	<u>J.</u>	18. Mother		18. Mother's Nen	r's Neme (First, Middle, Meiden Surneme)							
Maryland	Menta Menta arked	To B	John H. William					Parkhill							
	d 2 s		19e. informant's Neme/Relationship (T) Roland Purnell	/ Son			oten <i>d Number or R</i> u n Lane Fr			Stata, Zip Coi 1826	de)				
Baltimore,	Peges 1 end nent of Health nt: if item 27 iry or other tr		20e. Method of Disposition 1 Disposition 2 Cremetion 3 4 Donetion 5 Other (Specify)	Removel from Stete	Ob. Piece of Dispo	sition (Nema of netory or other pl	BCB)		20c. Location -	City or Town,	Stete				
Balti	parmit. Page: Department or Important: If i	ĺ	21. Signature of Furieral Service Licens			. Name and Addi	and Colombia	urbage l	Funeral	Home					
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vision of	S 00 0	2	1 Yes 2 No 27. Magner of Death Statural 5 Pending Accident investigation	1 Inpatient 28e. Deta of injury (Month, Dey Yea	2 ER/Outpatien 28b. Time of injury	28c. Inju	ther: 4 Nursing H	28d. Describe ha	nce 6 Otherwinjury occurre						
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	20		30. Name and address of muson who co	empleted cause of deeth	Item 23a) (Type,	Print)	Mn 21	811	10	-1-	- MARINE				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12:30 P.M MAGDALENA 26, 1999 Feb. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Sykesville Carroll 6618 Carroll Highlands Road If Under 24 Hrs. If Under 1 Year 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Steta or Foraign Country) 10 M 29 F Months Days Hours 93 Yrs. 27, 1905 Lithuania 216 30 2418 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Md. Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6618 Carroll Highlands Road 21784 U.S.A. 12. Was Decadent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, atc. 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT usa retired) (Specify only highest grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) Sewing Seamstress 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Antanas Sakalauskas Magdalena Mazlaveckaite 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6618 Carroll Highlands Rd. Sykesville, Md. 21784 Biruta M Baltrunas 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ➡Burial 2 ☐ Cramation 3 ☐ Removal from State Baltimore, Md. 3/1/99 Holy Redeemer Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility Sykesville, Md. 21784 21. Signature of Funeral Service Licensee Hai Haight Funeral Home & Chapel P.O.Box 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Immediate Cause (Final disease or condition rasulting in death) GENERATIVE DEMENTIA Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): HYPORTONSION 210485 VASCUCAR Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an eutopsy performed? 1 ☐ Yes 2 1 No 1 Yas 2 -No 25. Was case referred to medical examinar? 26. Placa of Daath (Check only ona)

Physician /Medical **Examiner**

requires that the death certificete be axecuted

Box 68760.

P.O.

Records,

Division of Vital

Hospital or Attending Physician:

Physician

/Medical

Examiner

10a State

Director

Funeral

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Completed

2

Funeral

Director

7 is marked other than "natural", or itams 23s or 28a-f show traumstic avant, the Medical Example must be notified at

with the Marylend

permit. Pages 1 and 2 should be filed within 72 hours after death with Depertment of Health and Manial Hygiena. Important: if tam 27 is marked other than any Injury or other traument.

Examiner Physician/Medical b Completed Be P

funeral Certification:

attending physician end for use as the burial-transit signed by the a peed paga 2 certificata has After this s efter deeth.

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within 24 hours of To the Funeral I

29a. Certifiar (Check only one)

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicida

6 Could not be determined 4 Homicida

28a. Date of Injury (Month, Dey Year) 5 Pending investigation

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Tima of

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pasidenca 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

25 LIBURTY RD ELDHRSBURG UD

28d. Describe how Injury occurred

1 Dertifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and mannar stated. 29b. Signature and title of certille unesus)

29c. License number

29d. Date signed (Month, Day, Year)

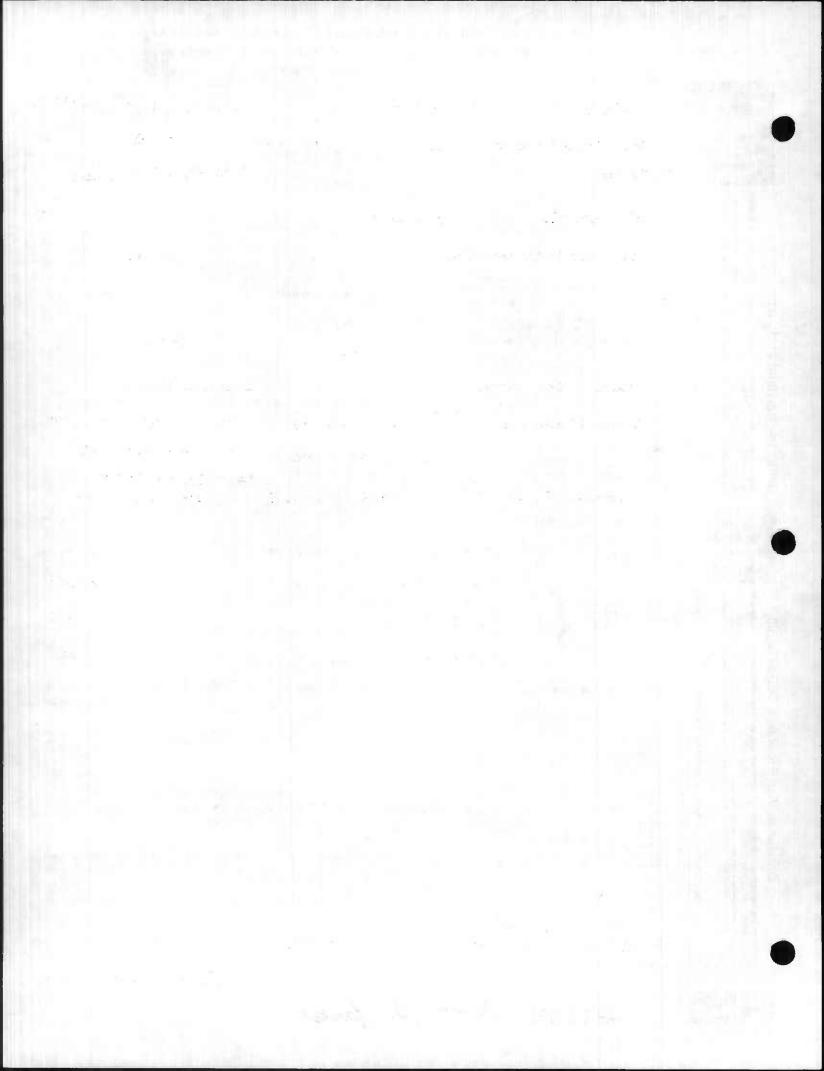
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) un

31. Date filed (Month, Day, Year)

MAR 0 1 1999

32. Registrar's Signature

State Registrar

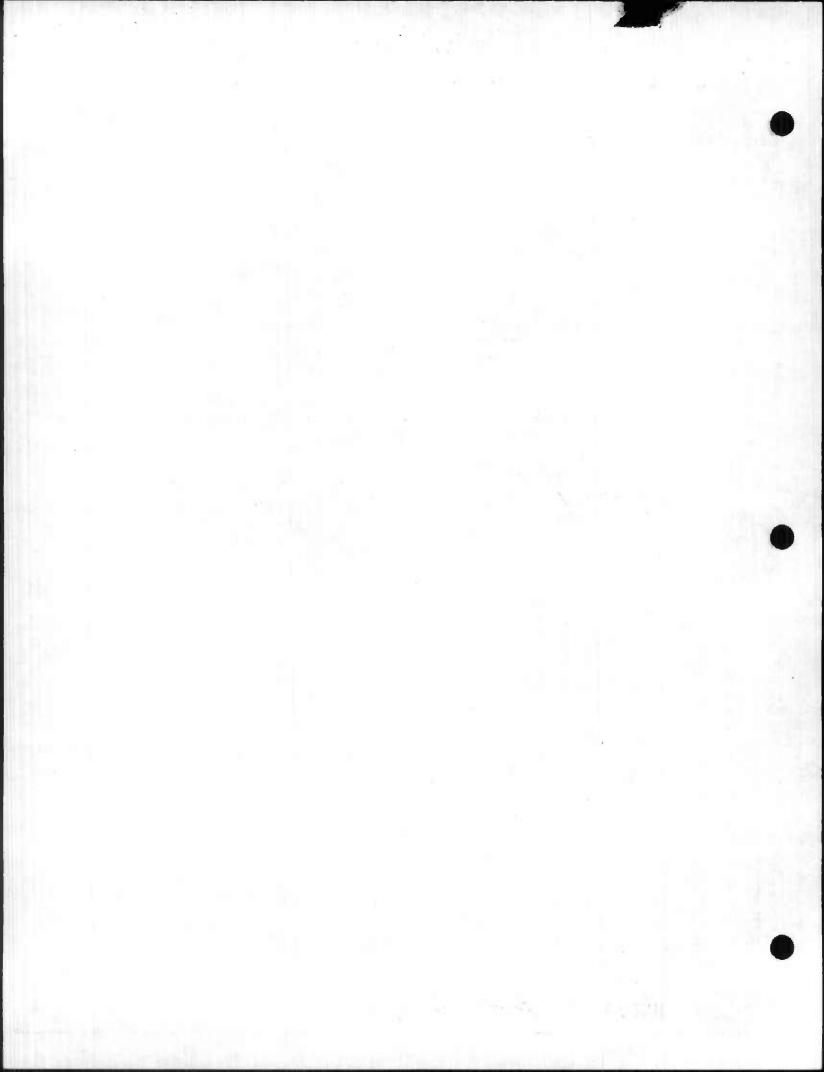


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMENDED: 9/29/22 7 State of Maryland / Department of Health and Mental Hygiene # 19a Allen R. Pryor wCHD/bbk 3/4/99 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Yaar Month **Physician** Prvor February 28, 1999 3:00 PM /Medical Virginia 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico If Undar 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Data of Birth (Month, Day, Year) **Funeral** Deys Months Hours 1□ M 25 F September 22, 1922 Yrs Director 76 252-22-3490 Ceorgia Usual Rasidance of Decedent September 29, 1922 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yas 2 No Maryland Wicomico Salisbury 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 늅 8 Berrs 23s 111 May Drive 21804 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. 72 hours after 1 ☐ Yes 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 X Married 'natural', or altimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene important if flem 27 is malertal Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Retail Sales Clothing 10 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) 89 Charles Connell Lois Feutrel 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) A Russell Pryor Jr./Husband
Allen R. Pupor
20a. Mathod of Disposition 20 111 May Dr., Salisbury, MD 21804 20b. Place of Disposition (Nama of cematary, crematory or other place) Date 20c. Location - City or Town, Stata 1 ⊠ Burial 2 □ Cramation 3 □ Ramoval from Stata 3/3/99 Salisbury, MD Parsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) etura of Funaral Service Licersaa 22. Nama and Addrass of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a Part / Entar tha disease, or complications that caused tha death. Do not entar tha mode of dying, such as cerdiac or respiratory arrest, speck, or heart tailure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical seumonos Examiner Dua to (or as a consequence of) Examiner Jamen Tor sen requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last attending physician and for use as the burial-tran Dua to (or as a consequanca ot): Box 68760 Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Wara autopsy findings available prior to complation of ceuse of death? Completed 24a. Was an autopsy The law page 2 s 1 ☐ Yas 2 Ø No 1 Yas 2/210 certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director; t Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yas 2 Ø No Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 28a. Data of Injury (Month, Day Year) 27. Magnar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending Invastigation 1 Natural 1 Yas 2 No 2 Accidant 3 Suicide 6 Could not be determined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 T Homicida within 24 hours a

To the Funeral C

completely filled edicai PC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signatura and title of certifiar 29d. Data signed (Month, Day, Year) 29c. License number 30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print) Drine, Solisus 28804 MATKINS mo 1104 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** J. March 1979 07/2 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMŁCO 6. Sex 1 M 2 F If Under 1 Year 8. Date of Birth (Month, Day, Year) April (4) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours MAL 72-1084 Yrs 959 Director 113-27 - 108 4 Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 1 Yes 2 No SALISBURG Director Mo 166 MICO 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23a or traumatic event, the Modical Examinar must be r AUB 324 80 454 Funeral Peges 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U,S Armed Forces? 1 Yes 2 Date If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Statue 1 Never Married 2 Married 1 Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiena. marked other than Etementary/Secondary (0-12) College (1-4or 5+) Douttake Poultur Shall Aloin Pits 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) end Mental FIDMAS VARRNCE BNIA 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Important: If item 27 is n any injury or other DAL Sterns LAGERL KOSER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Peremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lanatori 21. Signature of Funeral Service Licenses 22. Name and Addrass of F 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) preumonia day Examiner Due to (or as a consequence of) Examiner deficiency Immune acquired physician end s the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or trijury that Initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): attending p ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown p 24b. Were autopsy findings available prior to should 24a. Was an autopsy performed? Completed peeu completion of cause of death? s cartificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: director, 25. Was cese referred to medical examiner? 86 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1- Naturat 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after deeth. Be Funeral Director: A pletely filled in by the fi Investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical completely (Check only one)

Registrar

within 2 To the F

13. Charles Silvia 31. Date filed (Month, Day, Year)

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30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

1999

29b. Signature and title of certific

Jr 32. Registrar's Signature

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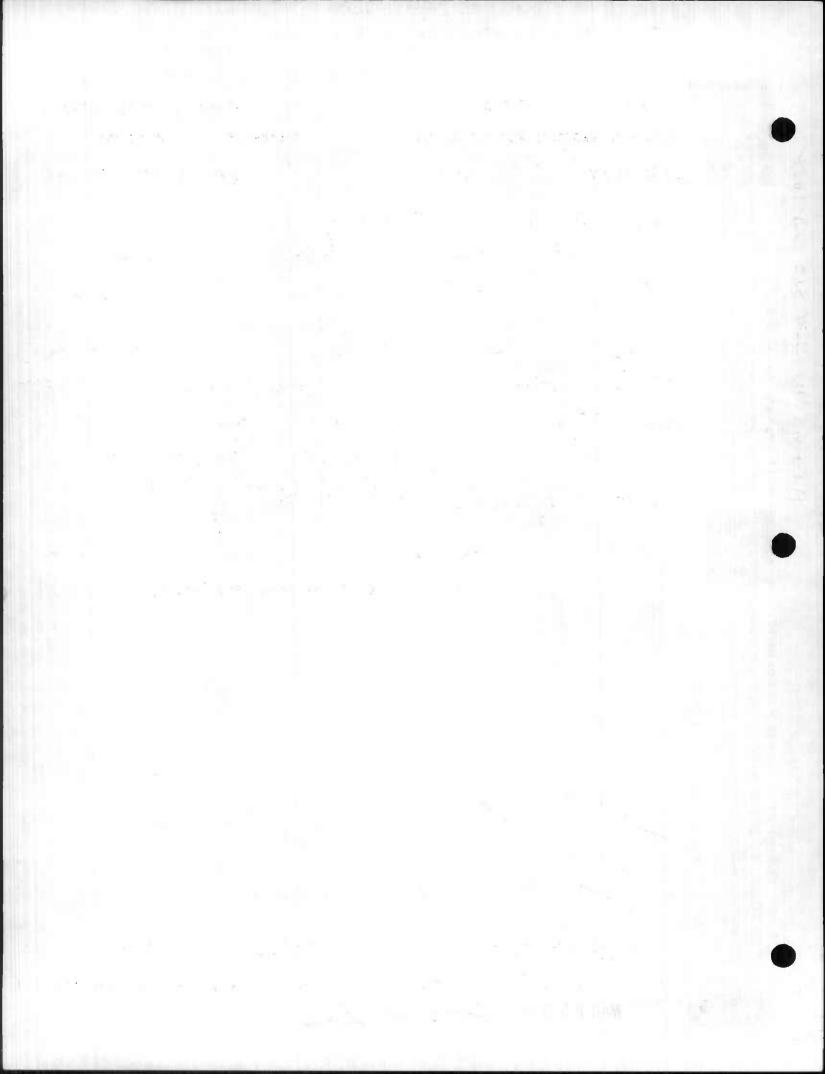
PRMC 100 Fact Cerroryt. Sal md 21801

29c. License number

D30853

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death Month February 1999 5:45PM 26 Ann Rice 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Birthplaca (Stata or Foraign Country)

1. Decedent's Nama (First, Middla, Last) **Physician** Patricia /Medical 4a Facility Nama (If not institution, giva street and number) Examiner 8296 Chestnut Grove Rd. If Undar 1 Yaar | If Undar 24 Hrs. 8. Dala of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Davs 1 ☐ M 2 🗓 F 53 Yrs. 219-46-2110 19, 1945 **Director** Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location Item 27 is marked other than "naturel", or items 23s or 28s-f show other trsumetic event, the Medical Examiner must be notified at Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21701 8296 Chestnut Grove Rd. permit. Pages 1 and 2 should be filed within 72 hours after death Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "nature!", or Items 23. Funeral 14. Race - Amarican Indian 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 □ Navar Marriad 2 □ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) retail customer service manager 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Ira Claude Bruchey Ola Louise Lochner 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Frederick, MD 21701 Michael J. Rice/ son 8296 Chestnut Grove Rd. 20b. Place of Disposition (Nama of cematary, cramatory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stala any injury or 3/2/99 nr. Libertytown, MD Chapel Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Hartzler Funeral Home 21. Signature of Funeral Sarvice Licenses attarine Libertytown, MD 21762 11802 Liberty Rd. 23a. Part1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** METASTATIC OVARIAN CANCER Immediata Causa (Final disaasa or condition rasulting In daath) /lilearcai Examiner Dua to (or as a consaquance of): Examiner physician and the burial-trans Sequantially tist conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medicai Dua to (or as a consequence of) 88 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes No

requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, signed t þ Completed has certificate or Attending Physician: Be 2 this funeral Certification: After after death. Director: Aft

25. Was casa rafarred to medical axaminar?

28a. Data of Injury (Month, Day Year)

3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performad? complation of causa of death? 1 ☐ Yas 28-No 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28d. Dascribe how injury occurred

5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined 3 Suicida Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28b Time of

29c. License number

28c. Injury at Work?

29d. Data signad (Month, Day, Year)

30. Nama and addrass of person who complated cause of death (itam 23a) (Type, Print)

M O' CONNOR 501

W. SEVENTH ST. FREDERICK MD 21701

Maryland

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10d. Insida City Limits

Approximata Intarval Between Onsat and Death

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State Registrar

Medical

1 Yas 2 No

29b. Signature and title of certifies

31. Data filad (Month, Day, Yaar)

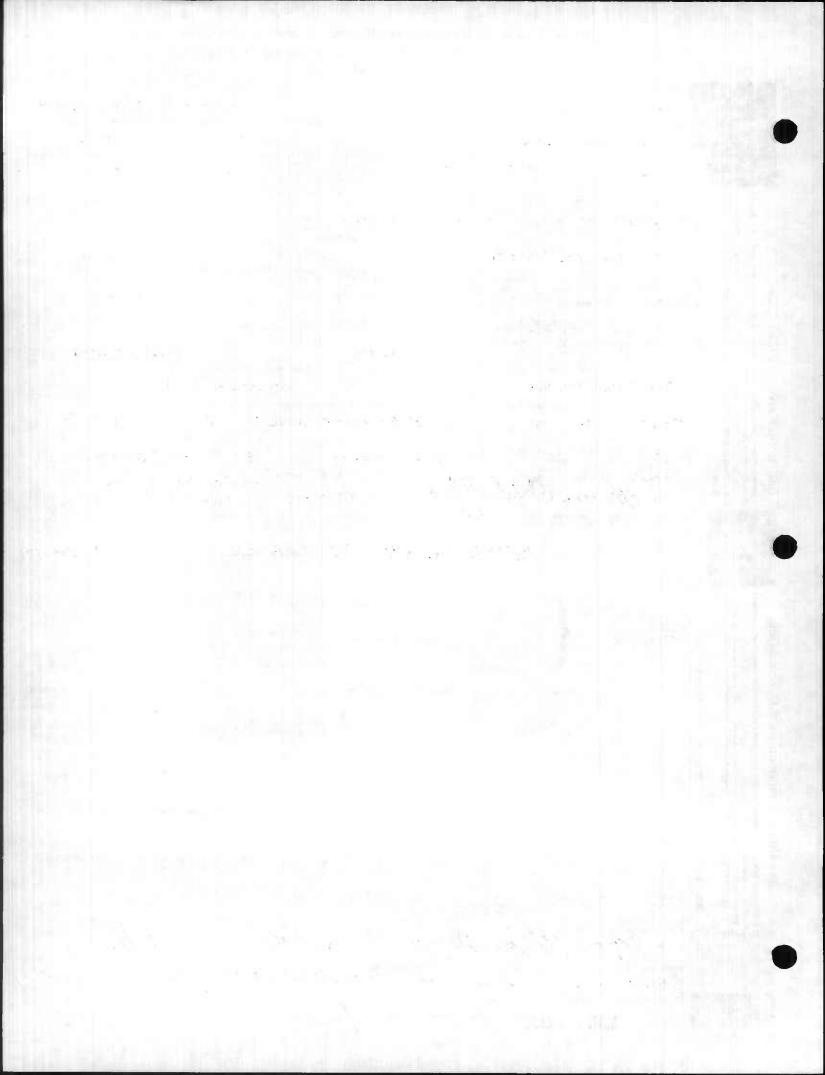
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32. Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Deta of Deeth **Physician** CANCE DICER /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner ARROLL CARROLL OSPILA OUNX If Under 24 Hrs. 8. Data of Birth (Month, Dey. Social Sacurity Numbar 9. Birthplece (State or Foreign Country) Age (In yrs. last birthday) Months Deys Hours 1 M 2 1 213-10-6614 86 MD Director with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at WESTMINSTER 1 Yas 2 No ARROLL Director 10f. Zip Code 10g. Citizen of Whet Country? 2115 Funeral 14. Race - Amarican Indian, Bieck, White, etc. 12. Was Decedant Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) nemit. Pages 1 and 2 should be filed within 72 hours attar Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No 1 Nevar Married 2 ☐ Married WHITE 1 Yas 2 No Specify: Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) College (1-4or 5+) Elementary/Secondary (0-12) BENDIX CORP CLERICAL 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) MYETLE SpicER EARLE TRACE 19b. Mailing Address (Street et 408 EAST DU ALL ANDELA CAMBRE OF Disposition (Name of cametery, cremetory or other place (Street end Number or Ruyal Royte Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) NANCY SIES DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremetion 3 Removal from State 6 ETOWIN CEMETER FREELAND, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility PRIHS FUNK HIZ WASHINGTON ROAD WESTMINSTER, MARYLAND 2115 Beatons that cause of the leath. Do not enter the mode of dying, such es cardiac or respiretory errest, FUNERAL HOME & CHAPEL 21. Signature of Forgeral Service Liceg 21157 Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final disaase or condition resulting in death) /Medical **Examiner** Due to (or es e consequence of) Examiner to (or es e consequenca of): ettanding physician end for use es the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting In deeth) Last Physician/Medical Dua to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. PO No 3 Probably 4 Unknown 1 Yss Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed has 2 200 1 ☐ Yes 2 ☐ No 25. Wes casa referred to medical exeminer? 1 Yes No 27. Manner of Death Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 Inpatient 2 ER/Outpetient 3 DOA After this funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 28e. Dete of Injury (Month, Dev Year) Certification: Neturel 5 Pending investigation or Attending 1 Tyes 2 No death. 2 Accident efter death 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D Cartifying Physician 29a. Certifier best of my kn ath occurred et the time, date end pleca, end due to the ceuse(s) and menner as stated. Medical basis of exan (Check only investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 30. Neme end eddress of person ino comp 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Month **Physician** 1999 ALICE KATHERINE RIGGIN FED. /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Yaar | If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplace (Stete or Foraign Country) **Funerai** 1 ☐ M 2 🛣 F Months Deys Hours Yrs 202-18-4189 79 Director JULY 14,1919 DELAWARE Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Director MARYLAND WICOMICO SALISBURY 10e Street and Number 10a. Citizen of Whet Country? 10f. Zin Code ŏ 238 707 RIVERSIDE RD. 21801 Funeral U.S.A. 12. Was Dacedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Dates: items ! 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, atc. 11. Marital Status 1 Never Married 2 Married natural, or 1 ☐ Yes 2 🗓 No þ Specify. 3 Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than "n any Injury or other traumatic event. Elementery/Secondery (0-12) College (1-4or 5+) INSPECTOR SHIRT FACTORY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be HARRY Ε. WALLER 2 MAMIE CANTWELL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JOAN V. GIVANS - DAUGHTER 32934 DIVISION ST. PARSONSBURG, MD 21849 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Crametion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL MEM. GARDENS 3-5-99 HEBRON, MARYLAND 22. Name end Address of Fecility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD. 21804 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cerdiac or respiratory errest shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting in deeth) DUDULL EAR5 Examiner Due to (or as e consequence of): Examiner sician and burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical Dua to (or as a consequence of) 98 ettending p P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Records, 24b. Wera autopsy findings eveileble prior to completion of causa of deeth? Completed 24a. Wes en eutopsy peen page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: director, 25. Wes cese referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this funerel Menner of Death 28e. Dete of Injury (Month, Dey Year) 28h. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation After Neturel d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide • Funeral [completely filled Hospital Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the the 29b. Signature and title of 29c. Licanse number 29d. Date signed (Month, Dey, Year) d eddress of person who completed cause of death (Item 23e) (Type, Print) 10 0 (0) one 31. Date (Month, Dey, Year) 32. Registrer's Signeture

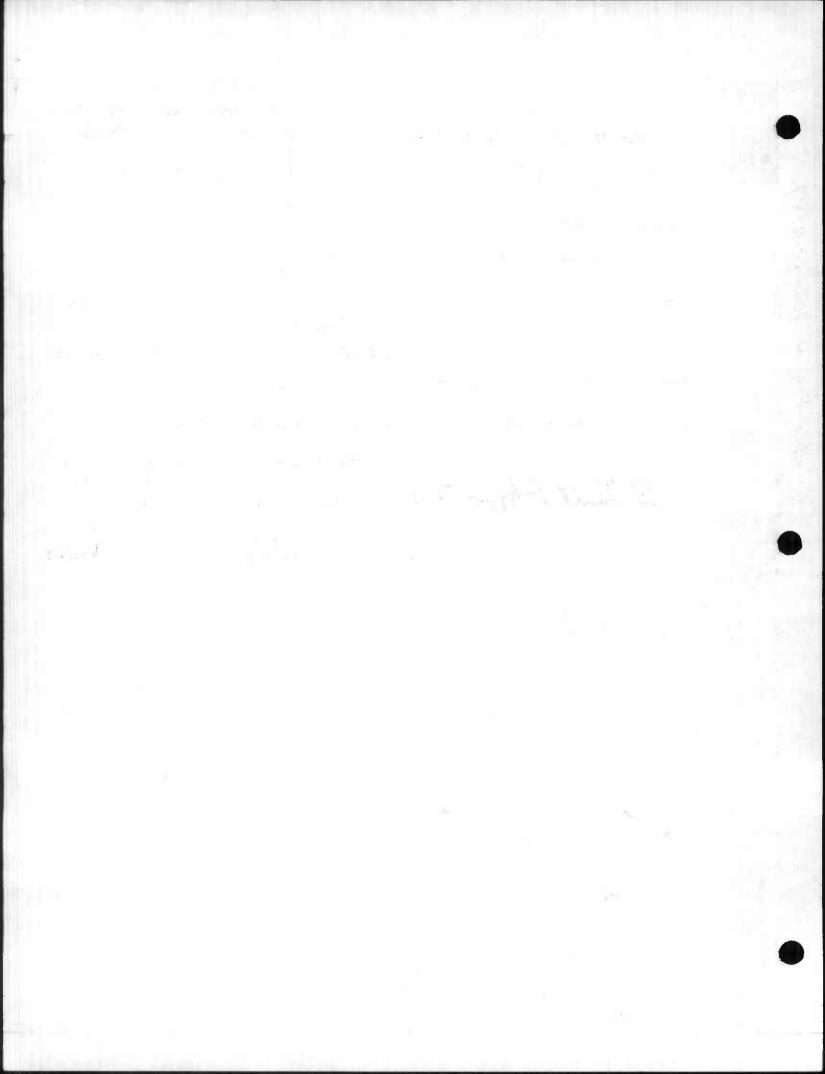
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Registrar

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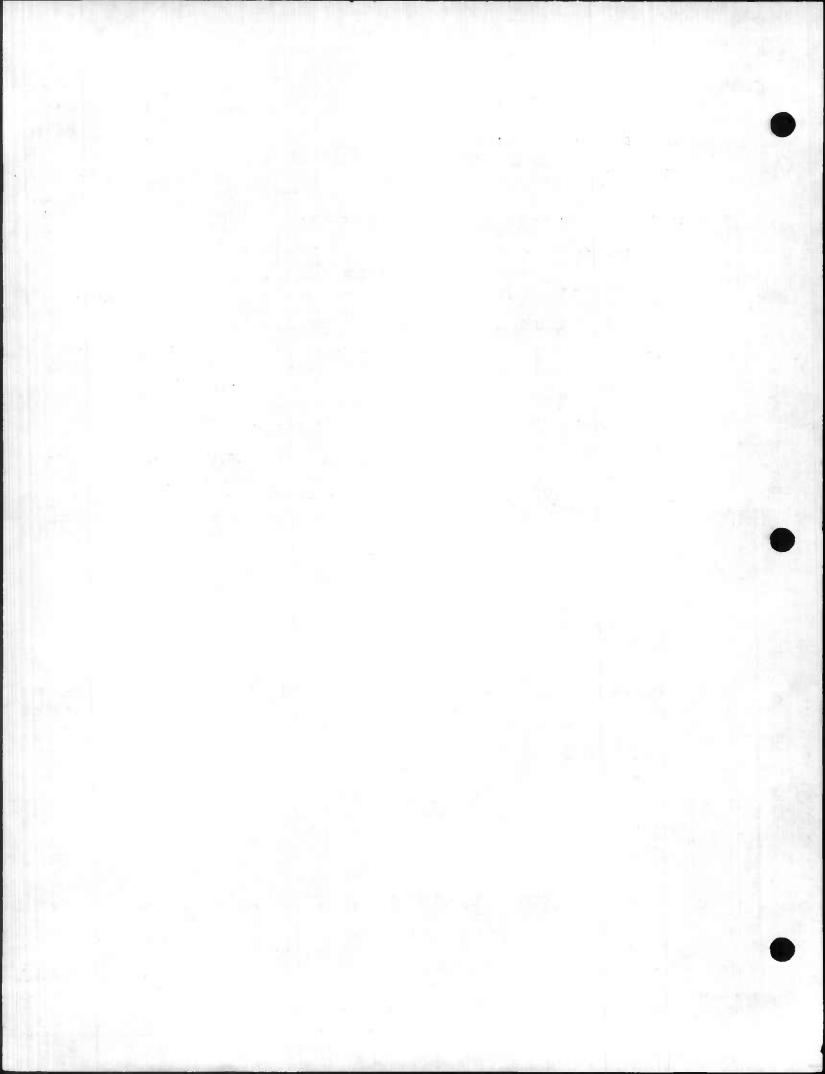


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	1. Decedent's Name (First, Middle, Last)		Certificate of		2. Date of Deat			3. Tima of Death				
Physician	OODEPHIE HALLE BRIEFIEL	Ε			Month	Day 19	Year	1300				
/Medical Examiner	An English Stome III and Institution who assessed and a	umber)		4b. City, Town, or Lo	ocation of Death	4c. County						
LAdiffile	Washington County Hosp	ital		Hagers	town	Wash	ningto	n				
Funeral Director	5. Social Security Number 6. Sex 121-24-2233 1□ M 2⊠ F	7. Age (In yrs. lest	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 13	Year) ,1933	9. Birthplac Country New Y	ce (Stata or Foreign ork				
show sides	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location		10d. Inside City Limits							
in the Mary or 28a-f shi a notified a	Maryland Washington		Hagerst	own	1 Dg. Citizen of What Country?							
Maryland 21215-0020 d 2 should be fixed within 72 hours after death with the Ma th and Mental Hygiene. The marked other than "natural", or items 23s or 28s-1s traumatic event, the Medical Exemples must be notified. To Be Completed by Funeral Director	10e. Street and Number 1212 Virginia Avenue	1.75	10f. Zip Code	21740								
	3 ☑ Widowed 4 ☐ Divorced If Yes, G	2 🖾 No	13. Was Decedent of It fi Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, atc.)		e - American ck, White, etc	C.				
	15. Decedent's Education (Specify only highest grade completed Elamentary/Secondary (0-12) College		Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work	ing	16b. Kind of Bu	usiness/Indu	stry				
	12 0	(1-0.54)	housewife	,			own ho	me				
	17. Father's Name (First, Middle, Last)			18. Mother's Name	e <i>(First, Middle, I</i> l ances Re		10)					
	Leo Angelo 19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailing Addrass (Street				Stata. Zin C	ode)				
Te, Ma 1 and 2 Health ar sem 27 is other treu	David Shindle - son		1214 Virgini									
Baltimore, semil. Pages I ar separating of Hoa myortanti II llend in yoriging or other side.	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	n State ceme	of Disposition (Name of stary, crematory or other pla Haven Cemete			20c. Location -		n, State Maryland				
Baliting Permit Poperant Important Important Informative Informati	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee			Maryland								
Ba Department of the partment	21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740											
	23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Deach line.	o not enter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	i A	oproximate nterval Between				
Physician /Medical	Immediate Cause (Final	Contract		Obst-onlin	7		one i	Onset and Death				
Examiner	disease or condition resulting in deeth) a.	Due to (or as	a consequence of):	0 051 07WW	(1	1015				
owcuted in and riel-transit	Sequentially list conditions,	Dua to (or as	a consequence of):				1					
68760, ficate be executed physician and is the burial-transit	Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events)	Due to (or as	a consequence of);									
W = == 0		,					i					
O. Box le death cer the attendin hed for use	Part II. Other significant conditions contributing to a	death but not resulting	g in the underlying causa given	ven in Part I.	23b. Did to	baçed use co	ntribute to t	he cause of death?				
requires that the death certifications is a detached for use a steed by Physician M. The steed b	Punte myoras	that 1	Martar		1 TY	es 2□ No	3 Probe	bly 4 Unknown				
	Sepris		V		24a. Was a perform		avail	autopsy findings able prior to pletion of cause				
The law ate has be page 2 s					1 🗆 Ye	s 2 No	of de	Yes 2□No				
Vital Indicate certificate rector, page Co	25. Was case referred to medical			26. Place of Deat								
Of Vita Physician: this certific and director,	examiner? 1 Yes 2 No Hospitaf:	Inpatient 2 ER	Outpatient 3 DOA Oth	her: 4 Nursing Ho	me 5 Reside	nce 6 Oth	er (Specify)					
On On Offing Phy. After this funeral funeral	The state of the s	of Injury nth, Day Year)	Time of lnjury 28c. fnjur Wo		28d. Describe ho	w injury occur	red					
Division of the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be datermined 28a. Ptac built	e of Injury - At homa, ling, etc. (Specify)	M 1 [1 Yes 2 No				Route Number,				
Offsel or offsel or offsel or offsel or offsel offsel offsel or of												
he Hospii in 24 hours he Funer pletely fill edical	29a. Certifier (Check only one) 12 Certifying Physician: To the tanders on the tanders and main and main tanders.	e best of my knowled basis of examination nner stated.	ge, death occurred at the til and/or investigation, in my o	me, date and place, opinion, death occurr	and dua to tha ca red at the tima, da	ausa(s) and ma ata and place,	innar as stat and due to th	ed. he cause(s)				
To the To the company of the	29b. Signature and title of certifier	17	29c. Licens	se number	2	9d. Date signe	d (Month, Da	ay, Year)				
	30. Name and address of person who campleted only	se of death (Item 23	(Type, Print)	(Gill	7100 1	tra en	160	MD21742				
State	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	1. 1	- WILL	1	100/08	5/0019	11/2/172				
Registrar	MAR 0 4 1999	Olypeira	D. Spar	Kal.								

DHMH 16 Rev 6/95

Shindler, Josephine



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Dorothy Elizabeth Smith MARCH /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ital

7. Age (In yrs. last birthday)

When the description of the property of Washington County Hospital Washington County 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1□ M 2 1 F Director 519-20-3540 Idaho Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumatic event, the Medical Examiner must be not find at 1 ☐ Yes 2 No Director Maryland Washington Co. Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10825 Allen Avenue 21740 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 2 Yes 2 No. 115/45
If Yes, Give 4/15/45 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 No Specify: Completed by White Specify. 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic avantage. Elementery/Secondery (0-12) College (1-4or 5+) 12 Federal Government 0 Secretary Baltimore, Maryland 17. Fether's Name (First, Middle, Last)
Wilfred W. McCurdy 18. Mother's Neme (First, Middle, Malden Sumeme) Elva M. Lyon 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kevin J. Smith/Son 1347 Vida Drive, Baltimore, Maryland 21207 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 St Buriel 2 Cremetion 3 Removel from State Hagerstown, Maryland Cedar Lawn Memorial Park Mar. 4 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Douglas A. Fiery Funeral Home art Enter the disease or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart failure. List only one cause on each line. 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Onset end Deeth Physician /Medical Immediate Cause (Final diseese or condition resulting in death) · intracranial bleed 1 week **Examiner** Due to (or es e consequence of): Examiner dependent diabetes noninsulin Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequence of): ettending physiclan for use es the burie hyper knsion Years Physiclan/Medical P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by , page 2 should be detec 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Be Completed 24e. Wes en autopsy performed? this certificate 1 ☐ Yes 2 ☐ No I or Attending Physician: effer death. Director: After this certifica 25. Wes case referred to medical 26. Place of Deeth (Check only one) exeminer? Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA ဥ 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) the funeral 27. Menner of Deeth 1. Naturel 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Atterwithin 24 hours efter ded To the Funerel Director completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Kuttner-Sands, ms March 1, 1999 Address of person who completed cause of deeth (Item 23a) (Type, Print)

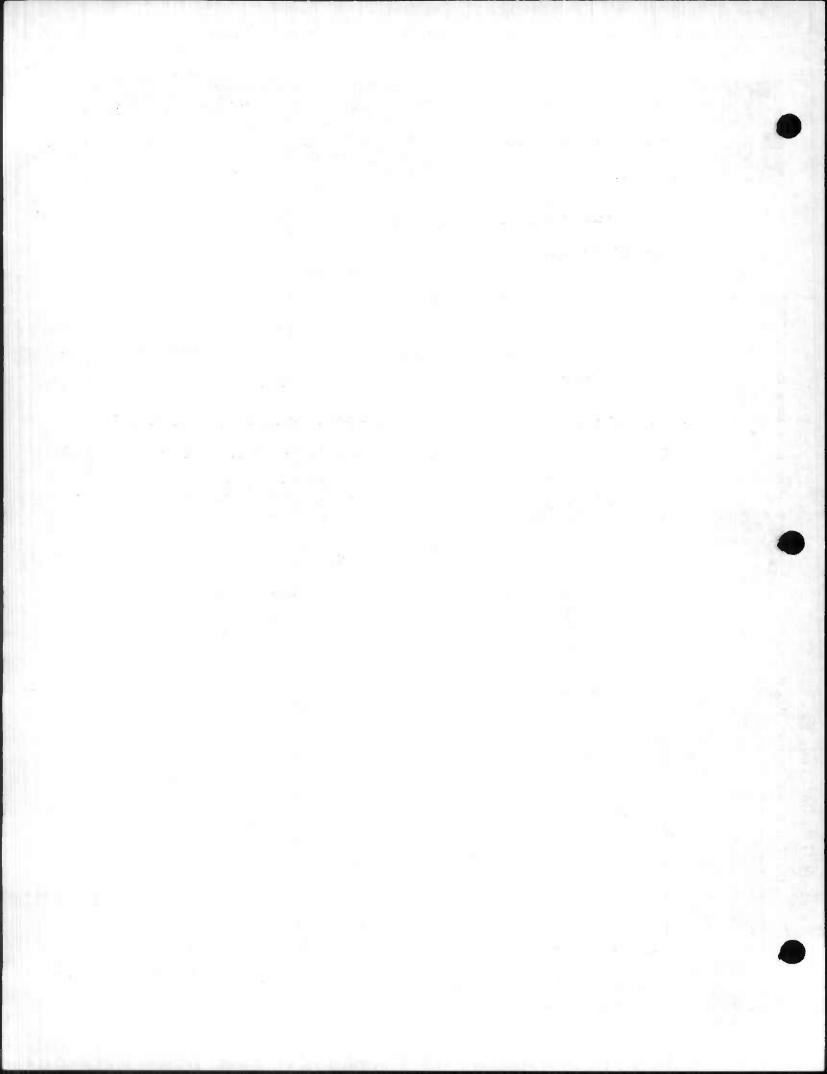
Kuthner-Sandsma 1110 Medical Campus Rd. Surte 130, Hagerstown, Mary land

Month Day Year) 2 1999

32. Registrar's Signature

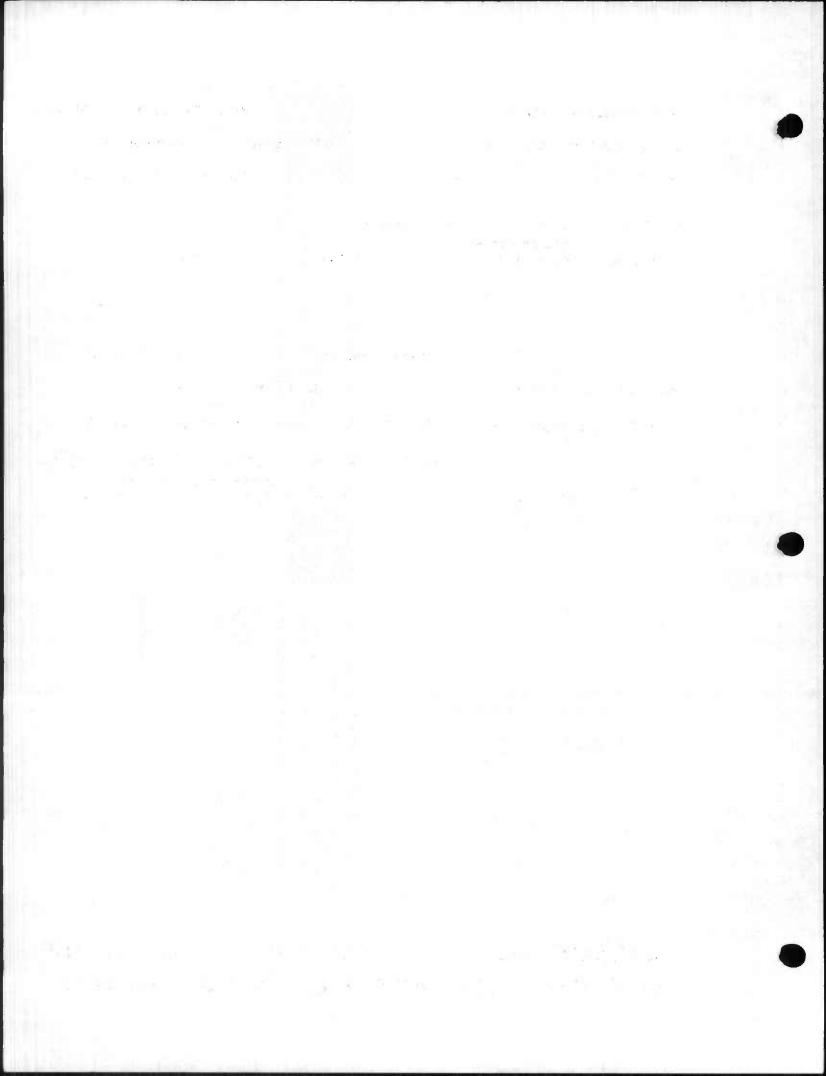
6. Sports 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 31. Dete filed (Month. State Registrar

MITH, Dorothy,



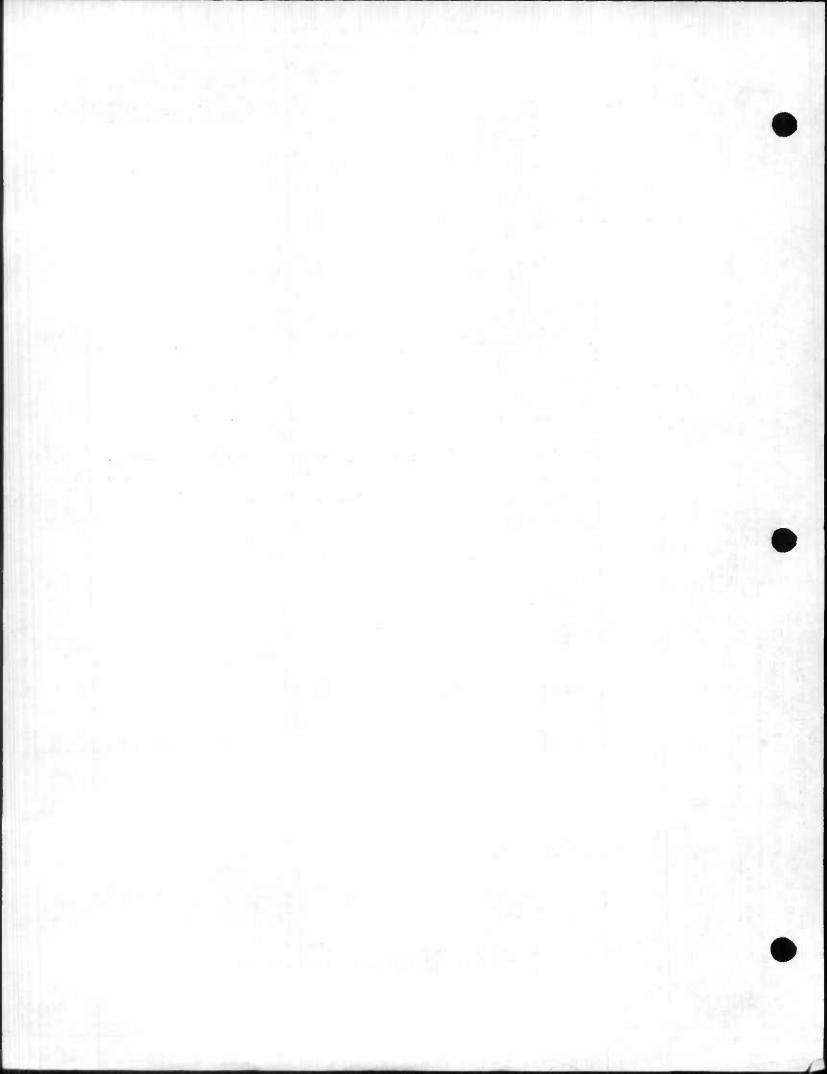
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

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So coal Security Number 1			Williamsport Nursi	ng Home				Williams	ort	Washi	ngton	
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15. Mother's Name (First, Mothes, Mattern Summer)	E 4	mpleted	(Specify only highest greda of Elementery/Secondery (0-12)	ompleted) College (1-4or 5+)					king		usiness/Ind	ustry
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23a. Part Lette the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate intered Between Physician (Modifical Examinar) Approximate the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Appr	permit. Departn Imports eny Inju		21. Signetura of Funerel Service Licensee									and
## Second Control of Cause (Final Immediate Cause (Final Impediate C	_		23a Part 1 Enter the disease or complicate	ions that saused the dee	th Done						Maryı	
Due to (or as a consequence of): Continue of the control of the	Physician /Medical Examiner	ı	Immediate Cause (Final disease or condition	PVEUMO	NIA						-	Intervel Between Onset and Deeth
Due to (or as a consequence of): Continue of the control of the	d ansit	mine	Sequentially list conditions	Due to (00 8 8 00	ueeuneuce, ou.					1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CACHEXIA DEHY DRATION 1 Yes 20 No 3 Probably 4 Unkr Value of death Va	e axec		if any, leading to immediate cause. Enter Underlying	540101	JI 43 4 00	nisoquonos oi).						
24e. Was an autopsy performed? 24b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No	E Ded		resulting in death) Last	Due to (c	or as a co	nsequence of):						
24e. Was an autopsy performed? 24b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No	death e atte	sicia	Part II. Other significant conditions contrib	outing to death but not ras	ulting in t	he underlylna c	ausa giv	an in Part I.	23b. Did	tobacco use co	ntribute to	the cause of dea
25. Was case referred to medical examiner?	s that the med by the e detech	y Phys										
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) 27. Menner of Death 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 According 1 Month, Dey Year 1 Month, Dey Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 1 Month, Dey Year 28d. Describe how injury occurred 28d. Describe how inju	iew require las been si 2 should t	npieted	SENILE DEMEN	TIA					24e. Was perfe	an autopsy ormed?	ava	ileble prior to
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27. Mentine of Death 1 20 20 20 20 20 20 20	clan: sertific ector		examiner?	oitel:			044		th (Check only	one)		
1 Month, Dey Year Injury Month, Dey Year Street			IL 168 2/2NO	1 □ Inpatient 2 □			A	4 Lowursing H)
28e. Pleca of Injury - At home, ferm, streat, fectory, office building, etc. (Specify) 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Signature and title of dertifier 29e. License number 29e. License number 29e. Certifier (Check only one) 29e. Certifier (Check only on	ending path. or: After he fune	ation	1 Neturel 5 Pending Investigation			ury	Wor	k?	280. Describe	now injury occur	90	
30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print) TED E. HOWE 7542 OVERLOOK DR. BOONSBORD, MD 21713	oltal or Att urs after d irei Direct illed in by	_	4 Homicide determined	building, etc. (Specia	(y)				City or To	wn, Stete)		
30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print) TED E. HOWE 7542 OVERLOOK DR. BOONSBORD, MD 21713	Me Host	edica	(Check only 2 Madical Examinar	On the besis of examine	wledge, o tion end/	death occurred or investigetion,	in my o	ne, dete end plece, pinion, deeth occur	end due to the red et the time,	cause(s) end ma dete end piece,	nner as ste end due to	eted. the cause(s)
30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print) TED E. HOWE 7542 OVERLOOK DR. BOONSBORD, MD 21713	To the Vilthir To the		29b. Signature and title of partifiar			290	. Licens	e number		29d. Deta signe	d (Month, E	Day, Year)
TED E. HOWE 754Z OVERLOOK DR. BUONSBORD, MD 21713			Jayour.	MD		C	100)33700)	Februan	126	, 1999
21 Date filed (Menth Day Veet) 00 Delived Objects			112				nr	DD B	YHIRDI	An MI	1 >	1712
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Ce	ertificat	e or	Death			Reg. No.				
Physician	1. Decedent's Nama (First, Middle, Las							2. Date of De	ath Day	Year o	3. Time of Death		
/Medical	Hazel Corbin Solo					dh Cin Tar	F	ation of Deeth	ry 25	1999	0024		
Examiner	4a Facility Neme (If not institution, give Washington County					Hager	stowr	1	Wash		on County		
Funeral Director	5. Social Security Number 235–32–1102 6. Se	7. Age (II M 2 🕮 F	n yrs. last birthda 83 Yrs.	Months	1 Year Days	If Under:	24 Hrs. Min.	B. Dete of Birt (Month, Da NOV • 13	, 1915		place (State or Foreign htry) Virginia		
pug *	Usuel Residence of Decedent 10a. State 10b. County	110	Oc. City, Town or	Location				10d. Inside City Limits					
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vith the M t or 28e-f be notifie	10e. Street and Number			10f. Zip Code 21742					10g. Citizen of Whet Country?				
ath w	1614 Woodlands Rur		-1-110				-i-0 (0	:4. VN-		SA	an Indian		
	11. Marital Status 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:				an, Mexican Specify:	gin? (Spec i, Puarto R	eify Yes or No- ican, etc.)	Blac	can Indian, etc. nite			
72 hours "natural",	15. Decedent's Edu	ucation	16a. Dec	edent's Usua	ol Occup	pation	ad ward in		16b. Kind of B	usiness/In	dustry		
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and 2 sh eith and 27 le m er treum	19e. Informant's Name/Reletionship (T. Lianna S. Mason/Da								er, City or Town, aryland				
permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Mones. To Be Compi	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3 □ I 4 □ Donetion 5 □ Other (Specify,	Removel from State	ne ol ther pla Oria	∞) al Par	k Ma	Date	20c. Location - William		own, State t, Maryland				
permit. Departm Importa any inju	21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Doug								uglas A. Fiery Funeral				
80 5 5 8	(L) Leugent Luny 1331 Eastern Blvd., N., Hagerstown, Ma												
Physician /Medical	23a. Pertil. Enter the disease, of comp shock, or heert feilure. List only o	lications that ceused the one cause on each line.	death. Do not e	nter the mod	e of dyi	ng, such as	cardiac or	respiretory er	rrest,	5	Approximate Interval Between Onset end Deeth		
Examiner	disease or condition resulting in death)		e to (or es a cons							1	7 /2 years		
Sertificate be executed ding physician and sa as the burial-transit	Sequentially list conditions, if any leading to immediate												
certificate be executed tiding physician and isa as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
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at the death of by the attended for u	Pert II. Other eignificant conditions co	ntributing to death but n	ot resulting in the	underlying c	ause gi	ven in Part I.		23b. Did	tobacco uee co	ntribute t	o the cause of death?		
								10	Y•• 2□No	3 □ Pro	bably 4 Unknown		
									en eutopsy rmed?	av	ara autopsy findings railable prior to omplation of cause death?		
sician: The law secrificate has birector, page 2 s								10	Yes 2 No	1[□Yas 2□ No		
yelclen: The la director, page	25. Was case referred to medical examiner?					26. Place	of Deeth	(Check only o	ona)				
Physician: this certific ral director,	1 Yes 2 No	7		dence 8 □Oth		(y)							
Affect Affect Ion	27. Menner of Deeth 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28a. Date of Injury (Month, Day Year) 28b. Time of Injury					28d. Describe how Injury occurred					
To the Hospital or Atlanding Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification: "	3 ☐ Suicide 4 ☐ Homlcide 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street, factory, office building, etc.)								Street and Number of Rural Route Number, wn, State)				
he Hospit in 24 hour he Funera pletely fill edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated.										stated. the ceuse(s)		
Within To the comp	29b. Signature and title of certifier 29c. License number								umber 29d. Date signed (Month,				
	Michael J. Mulamet MP. D41667 2.25.								5.99				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael M. Corneck 11110 Medical Canpa, Rd Suite 130 Hagarihan MD. 21742												
State	31. Date filed (Month, Day, Year)	32. Registrar's			242 4	1		7,77					
Registrar	FFR 7 K 190	44		· ICH	CAL A	11							



State of Maryland / Department of Health and Mental Hygiene 3. Tima of Death

				Certificate	e of	Death		Reg. No.	U) 143		
Physician	Decedent's Neme (First, Middla)						2. Data of De Month	Day	Yaar	3. Tima of Death		
/Medical	ADA	SPU	IRRIER				FEBRUA	RY 26,	1999	8:03 AM		
Examiner	4a Facility Nama (If not institution,	give streat end number	r)		4b. City, Town, or Location of Death 4c. County of							
	Frederick Memo	rial Hospit	al			Frede	F:	ick				
Funeral Director	5. Sociel Security Number 205-36-8409 Usual Rasidance of Dacedant	6. Sex 7. A 1 □ M 2 ☑ F	ge (In yrs. last bir 53	thday) If Under Yrs. Months	1 Yaar Days		8. Data of Bir (Month, Da Oct. 26	th Year) 5, 1945	9. Birthp Cour Penns	placa (Stata or Foreign ntry) Sylvania		
ž	10e. State 10b. County		10c. City, Tow	n or Location					1	Od. Inside City Limits		
28a-f show notified at	Maryland Fre	derick	F	Frederic	k					1 ☐ Yas 2 🗓 No		
23e or	10e. Street and Number			10f. Zip	Code			10g. Citizan of	What Cour	ntry?		
	11205 Daysv	ille Rd.	1.			1701		U.	S.A.			
ner ner	11. Maritel Status	12. Wes Decadant Armed Forcas	t Evar in U,S.	13. Was Dacedant If Yas, specify		Hispanic Origin? (Sp	pecify Yas or No					
or items miner m	1 Navar Marriad 2 Marrie	ed 1 Yes 2 X					o Hican, atc.)		ack, Whita,			
by E	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yeer or Datas:		1□ Yas 2	Z (A) NO	Specify:		Speci	ity: Wh	ite		
"natural", social Ex	15. Decedant' (Specify only highest	Decedant's Usua (Giva kind of wor	l Occu rk done	pation during most of work	king	16b. Kind of E	Businass/In	dustry				
other then "natural event, the Wasterl Be Completed	Elementery/Secondary (0-12)	College (1-4or	5+)	(Giva kind of work done during most of w life. DO NOT usa retired) homemaker			f working OW			e		
C	17. Fether's Nema (First, Middla, L	ast)				18. Mothar's Nam	na (First, Middla	, Meidan Suma	ma)			
arked on atic ev	Ray L. Strik	e			Myrtle Garber							
EĘ	19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip											
n 27 ner t	Marlin L. Spurr	ier/ nusbar										
1: 17 17e	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion		8 .	20b. Place of Disposition (Name of cemetery, cremetory or other place) Chappel Competers 2 3/1								
netru .												
Important: if item 27 is any injury or other trai 2058.	21. Signature of Funa al Sarvice L	. Blothus	L			erty Rd.	rtzler l Libert					
	23a. Part1. Enter tha disaasa, or o shock, or haart failura. List o	complications that cause only one cause on each	ad tha daath. Do i lina.	not antar tha mod	a of dy	ing, such as cardiac	or raspiratory a	errest,	- 1	Approximete Intarval Batwaan Onsat and Death		
sician	The second second second	1	1 1							Orisat and Death		
edical miner	Immedieta Causa (Final disease or condition resulting in death)	a Meta	ustatic	- Do	In	creatic	Can	cer		6 Years		
	resulting in death)			consequence of):								
I by the attending physicien and eteched for use as the burial-transit. Physician/Medical Examiner	Sequantially list conditions,	b	Dua to (or es a	consequance of):								
ourial-	Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury											
g physician and es tha burial-transit fedicai Examir	Cause (Disease of mjury that Initiated avants rasulting In deeth) Last Due to (or as e consequence of):											
r use e		d										
d by the attending eteched for use es	Part II. Other significant condition	ns contributing to death	but not rasulting in	n tha undarlying c	ausa gi	van in Part I.		./		o the causs of death?		
Ph Ph							1 🗆	Yes 2000	3 Pro	bably 4 Unknown		

To the Hospital or Attending Physician: The law requires th within 24 hours after death.
To the Funeral Director: After this carificata hes been signed complately filled in by the funeral director, page 2 should be dominately filled in by the funeral director, page 2 should be dominately filled in by the funeral director, page 2 should be dominately filled in by the funeral director, page 2 should be dominately filled in by the funeral director. Completed by Be Certification: To

Division of Vital Records,

24a. Wes en eutopsy performed?

24b. Wara autopsy findings available prior to completion of cause of daath? 1 Yas 2 No 1 ☐ Yas 2 ☐ No

25. Was case referred to medical axaminar? 26. Place of Death (Chack only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 27. Mannar of Daath 28b. Tima of 28d. Dascriba how Injury occurred

1 Natural 5 Panding investigation 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Cartifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at tha time, date and place, and dua to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed, (Month, Day, Year)

30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print)

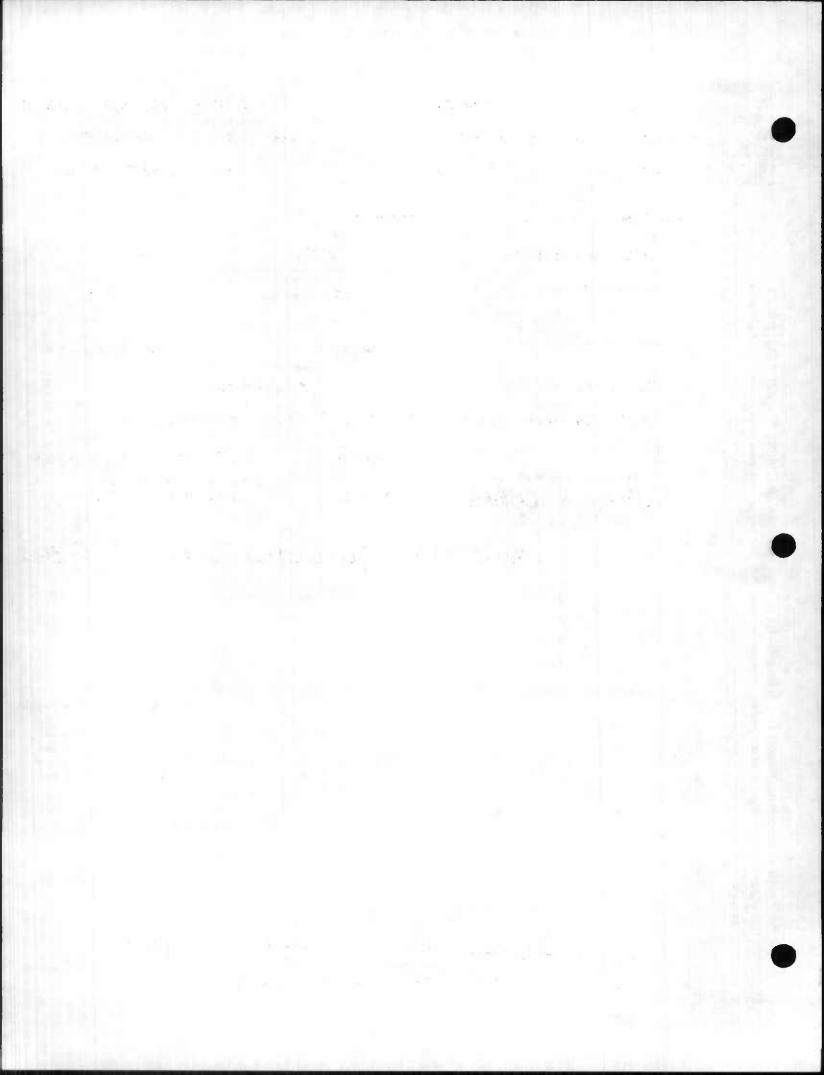
501 W. 7th St. Frederick, MD 21701 Elhamy Eskander 31. Data filed (Month, Day, Year)

State Registrar

Medical

MAR 0 2 1999





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death February 23 **Physician** Edna Tolliver 1999 4:00 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner 12101B Glissans Mill Rd. Union Bridge Frederick 8. Deta of Birth (Month, Dev. Year)
Dec. 28, 1912 West 5. Social Security Number if Under 1 Yaar If Undar 24 Hrs. Birthpieca (Steta or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2[XF Months Days Hours Min 232-74-8767 Yrs. Virginia Director 86 Usual Rasidance of Dacedent with the Maryland 10e Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28s-f show other traumatic event, the Modical Examinat must be notified at 1 Yas 2 No Frederick Maryland Union Bridge Directo 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 21791 U.S.A. 12101A Glissans Mill Rd. permit. Peges 1 and 2 should be filed within 72 hours after deeth v Department of Haalth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxicen, Puarto Rican, atc.) 14 Race - American Indian 1 ☐ Yas 2 ☑ No If Yas, Give Yeer or Datas: 1 □ Navar Marriad 2 □ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 Nidowed 4 Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) homemaker own home 18. Mother's Nama (First, Middla, Meiden Sumeme) 17. Fethar's Neme (First, Middle, Last) Arthur Akers Oma Ann Lester 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informant's Name/Relationship (Type, Print) 12101B Glissans Mill Rd. Union Bridge, MD 21791 Marion Hazelwood/ son 20b. Placa of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata any Injury or 2/26/99 Elgood, W. Va. Elgood Cemetery 4 □ Donation 5 □ Other (Specify) 22. Nama and Addrass of Fecility Hartzler Funeral Home 21. Signature of Fugarei Sarvice Licensee New Windsor, MD 21776 P.O. Box 249 23a. Part1. Enter the disease, or complications that a used the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on accumum. Approximate Interval Batween Onset and Death **Physician** immediata Causa (Final disaasa or condition resulting in daath) /Medicai Examiner Examiner Kereni The law requires that the death certificate be executed attanding physician and for use as the buriel-trans Sequantially list conditions, if eny, laading to immediata ceusa. Entar Undarfying Causa (Diseasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): use as t 23b. Did tobecco use contributa to the cause of deeth? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown signed by Division of Vital Records, þ 24b. Wara autopsy findings availabla prior to complation of ceuse of daath? 24e. Wes en autopsy performed? Completed cartificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No or Attending Physicien: funeral director, 25. Was man afarred to madicel Be 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Sothar (Specify) Son 5 2 1 Yes 2₽ No 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of injury (Month, Dey Year) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Tima of 28c. tnjury at Work? Certification: has: clarce 1- Neturei 5 Pending 1 Yas 2 No 24 hours after death. Funerel Director: Af invastigation 2 Accidant 6 Could not be determined 281. Location (Straet and Number or Rural Routa Number, City or Town, Stete) 3 Suicida 28e. Piece of injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital Medical 1 🗂 Certifying Phyeician: To tha bast of my knowledga, daath occurrad at the time, date and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of Specific completed ceuse of deeth (Item 23a) (Type, Print) 30. Nama end address-of person w

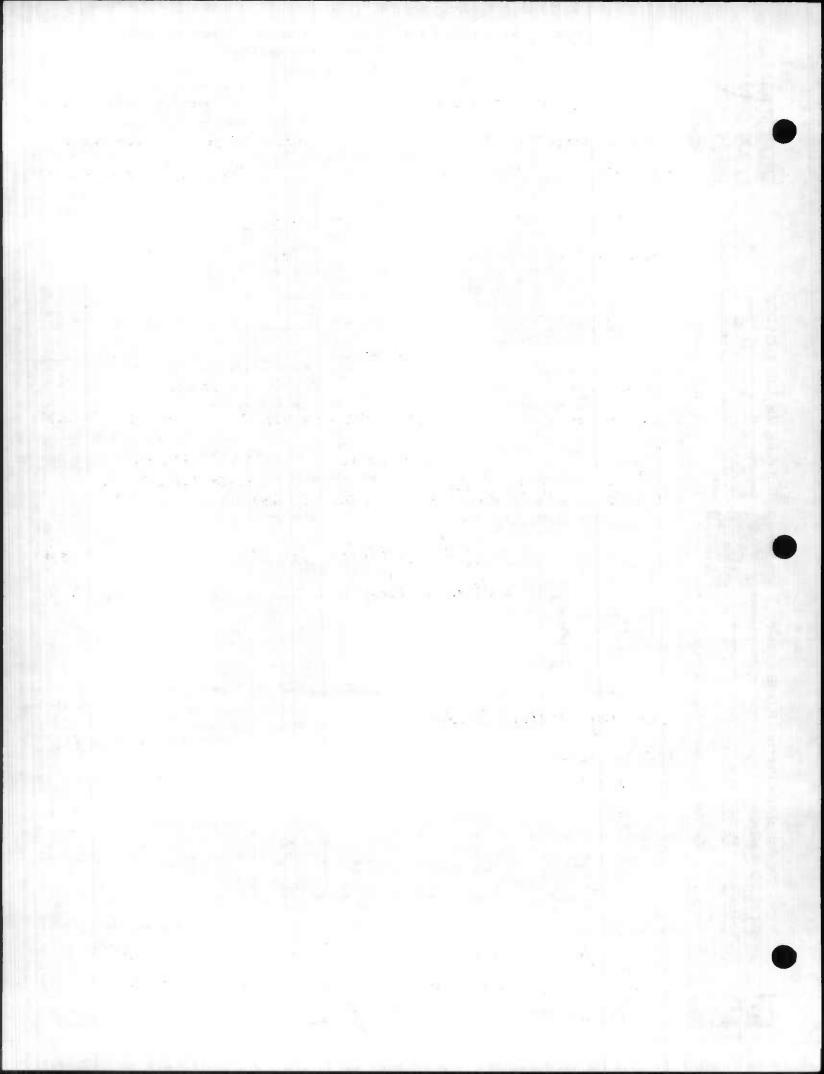
32. Registrar's Signatura

ay Anders

Registrar

-100 31. Data filed (Nonth, Day, Year)

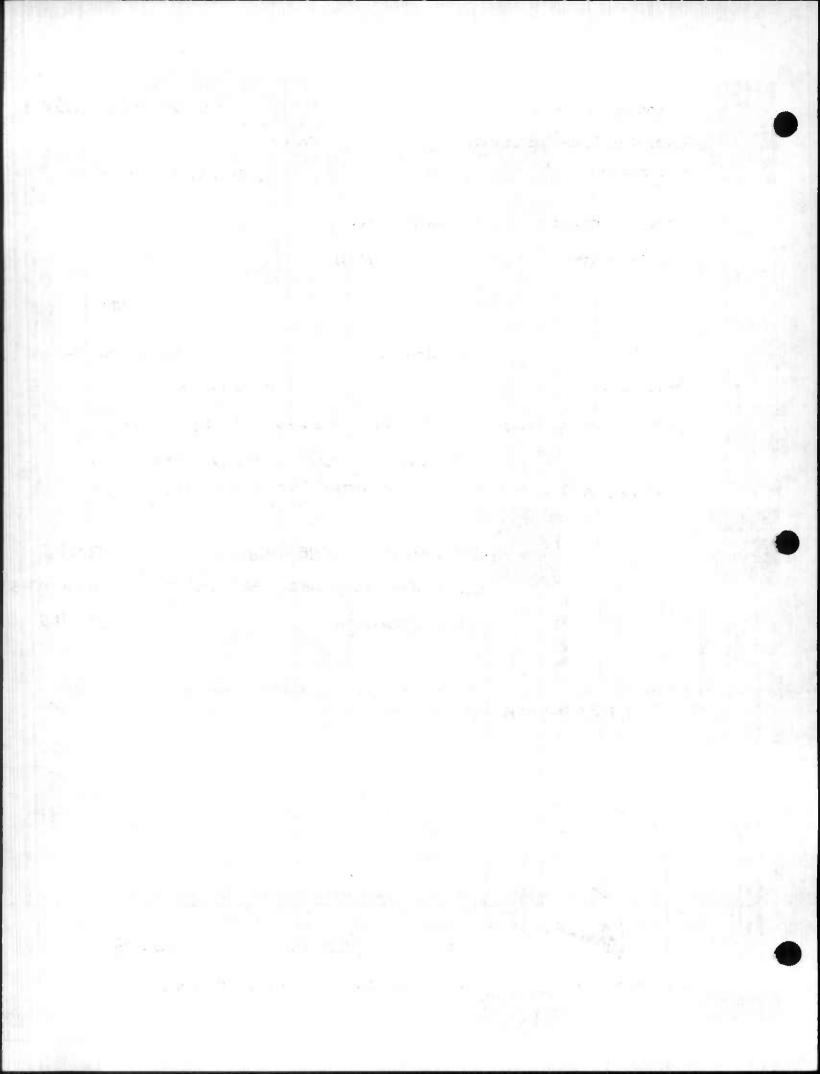
FEB 2 6 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death

Physician /Medical Examiner
Euporol

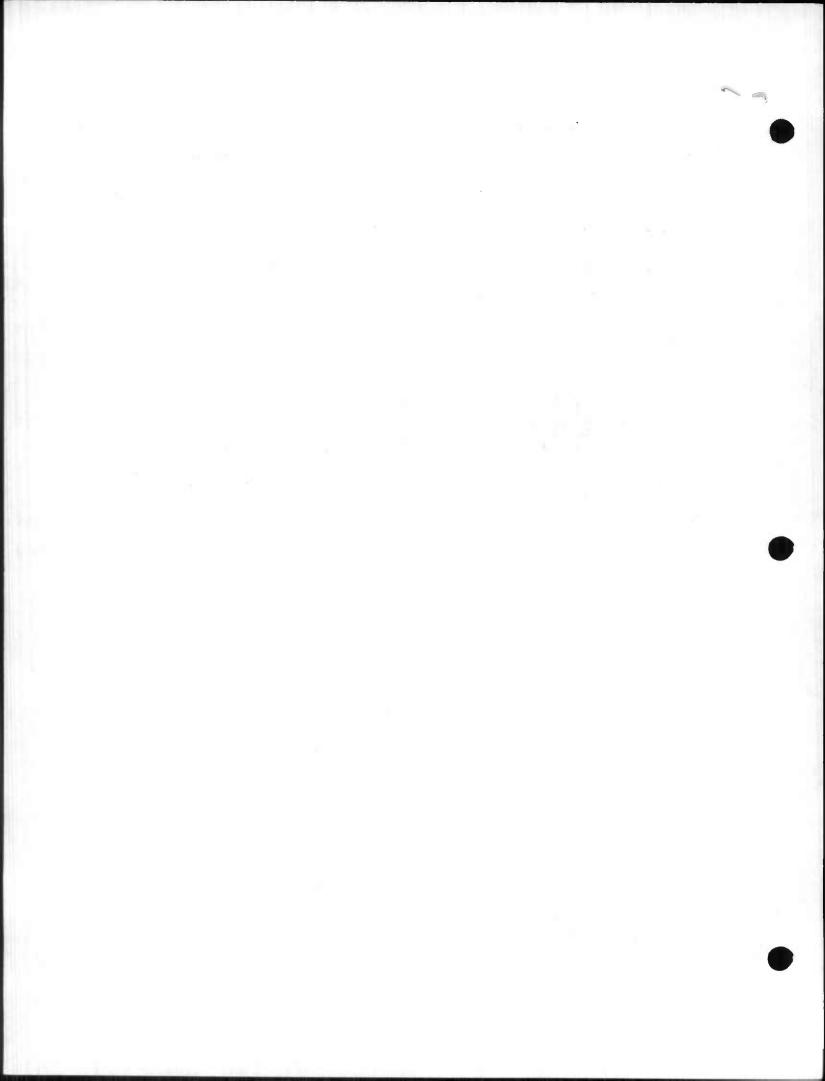
	OLD BY		1. Decedent's Neme ((First, Middle, Last)							2. Dete of De	eath		3. Time of Deeth
	Physic		John Jam	nes Van E	SS						March	Dey 2	1999	2:10 AM
	/Medi Examii		4a. Fecility Neme (If n)			4b.	. City, Town, or L			inty of Deeth	R. I.O.
			Alice Byrd	Tawes N	ursing Ho	ome			(Crisfiel	.d	Son	nerset	
	Funeral	Г	5. Sociel Security Nun	mber 6. Sex			lest birthday)	if Under 1 Ye		If Under 24 Hrs. Hours Min.	8. Date of Bi			plece (State or Foreign ntry)
	Director		363-14-719 Usuel Residence of D		JM 2UF		88 Yrs.	INOTALIS DO	,,,,	Tiours Iviai.	Jan. 5	1911	Mic	nigan
	show	5		10b. County			y, Town or Lo							10d. Inside City Limits
	the N	Director	Maryland 10e. Street end Numb	Worceste:	r	Po	comoke	City	la l			40 00	4117	
	with with											10g. Cltizen		ntry7
	death	Funerai	3715 Payne		12. Wes Decedent	Ever in U	.S. 13. \	21851 Was Decedent		penic Origin? (Sc	ecify Yes or No		JSA Rece - Ameri	can Indian.
020	should be filed within 72 hours efter death with the Marylend of Mentel Hygjene. marked other than "natural", or items 23s or 28s-f show imatic event, the Medical Ensister mark be notified at	by Fur	1 ☐ Never Married 3 ☐ Widowed 4		Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give Yeer or Dates:			f Yes, specify C 1 □ Yes 2 🔼 I		penic Origin? (Sp , Mexican, Puerto Specify:	Rican, etc.)		Black, White,	etc.
21215-0020	2 hou		15	5. Decedent's Educ	cation		16e. Deced	dent's Usual Oc	cupati	ion		16b. Kind o	WII.	
215	filed within 72 Hygiene. rther than "nat	Completed	(Specify Elementery/Second	only highest grede	completed) College (1-4or	5+)	(Give	kind of work do DO NOT use re	ne du	ring most of worl	ring			
	filed within Hygiene. other than ent, the Ment	Con	11	, (0 12)	Comogo (1 401		Shoe M	aker				Nation	nal Sho	oe Service
nd	tel Hy d oth	Be (17. Fether's Neme (Fil						1	8. Mother's Nam			neme)	
3	should be nd Mentel marked o	2	Jacob Van							Hattie		-0-0-0-0		
Maryland	O1 65 69 5		19a. Informent's Nem							nd Number or Ru				Code)
45	eall eal		Robert E. 20e. Method of Dispos		(son)	20h B		Payne R		d, Pocom				
وَ	or or		1 ☐ Burial 2 🖾	Cremation 3 R	emovel from State	C	ametery, cren	netory or other	plece)	1	Dete		on - City or T	
altimore,	it. Printme		4 ☐ Donation 5	Other (Specify)		Sal		Cremat			/6/99	Salish	oury, l	MD
g	permit. Pages 1 Department of H Important: If ites any injury or out once.		21. Signeture of Fore	1 Dec	mo112	-9		Neme end Ad Olloway		elson Fu	neral H	Home, H	A.	
	_	_	23e Parti Enter the	disease or compli	nations that sauce	d the deet	1	03 Lino	len	Ave., F	ocomoke	City,	MD 2	
	Discortate or		23e. Pert1. Enter the shock, or heert for	eilure. List only on	e ceuse on eech li	ine.	1. Do not ente	er the mode of (oying,	such es cardiac	or respiretory e	errest,		Approximate Intervel Between Onset end Deeth
)	Physician /Medicai		Immediete Ceuse (Fin	nel	Δ.	257.6	2 01	a at	0.	1611.0			1	1
	Examiner	ч	diseese or condition resulting in deeth)	е	1) 5				ų r	NEUM	0 WIH			2WKS
	- *	ner			C		r es e conseq		UL	AR A	CCIDI	EATT	İ	2 MO NTZ
	be executed Iclan end burial-transit	Examiner	Sequentially list condi	itions. b			r es e conseq			1700		0.4)		2 MONTE
Ď,	e exe		Sequentielly list condi- if eny, leeding to Imme cause. Enter Underlyi Ceuse (Diseese or inju- thet initieted events	ediete ing		Huf	ERTE	NOIDH						25 YRS.
09/89	sate b	dica	thet initieted events resulting in deeth) Les	st C.		1	es e consequ							11.00
20X 6	ath certificate be executed trending physician end or use es the burial-transit	lan/Medicai		d										
2	atten I for u													
	the de y the a	Physic	Pert II. Other significa						given	In Pert I.				o the cause of death?
7	v requires that the dea been signed by the a should be detached f	by Pi	CP	+RCINO	MAC	F	Colon	1.			10	Yes 2∐N	o 3∐ Pro	bebly 4 Donknow
necords,	quires on sig uld b										24a. Wes	en eutopsy	24b. W	ere eutopsy findings
5	law re	plet									perto	med?	co	elleble prior to mpletion of cause deeth?
	The la	Completed									10	Yes 2010	1	Yes 2 No
	sician: The lav certificete hes irector, page 2	Be C	25. Wes case referred	to medical					2	26. Plece of Deet		The state of		2 100 2 2 110
5	Attending Physician: ar death. ector: After this certific by the funeral director.	10	examiner?	He	ospitel: 1 Inpatie	ent 2	ER/Outpatient	3□ DOA	Other:				Other (Special	'v)
) =	neral		27. Manner of Deeth	5 Pending	28e. Date of Inju (Month, De	ry v Year)	28b. Time of Injury	28c. Ir	njury e Vork?		28d. Describe			
	eath. or: A	catio	2 Accident	Investigation						s 2 No				
5	after d after d Direct d in by	Certification:	3 ☐ Suicide 6 4 ☐ Homlcide	determined	28e. Pleca of Inj building, et	ury - At ho c. (Specify	me, ferm, stre	eet, factory, office	Ce C		28f. Location (City or To	Street end Nu wn, Stete)	m <i>ber or R</i> ure	el Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	edical C	29a. Certifier 15 (Check only one)	Certifying Physi Medical Examine	cian: To the best of the basis	exeminet	vledge, deeth ion end/or Inv	occurred et the estigation, in m	time, y opin	date end plece, ilon, deeth occur	and due to the red et the time,	cause(s) end date end pled	menner es s a, end due te	tated. o the cause(s)
	Vithin Fo th	Me	29b. Signature en title	of certifier	/			29c. Lice	ense n	umber		29d. Date sig	ned (Month,	Dey, Year)
) la	Mary				D 5	10	86		3-2	-99	
		-	30. Name end eddress	of person who con	npleted cause of d	eeth (Item	23e) (Type. F		, 0			9 3	- 1 1	
			Dr. Eshwar						+ .	Cristie	Id. MD	21817		
I	Sta	te	31. Dete filed (Month, I	Dey, Year)	32. Registra			/						
	Ponietre		0.0.00	n n 9 1444	4 / 2 -4.04		/-/	1100.6	1. 1					



examiner must be notified at once	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
st. examiner must be notified at once	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
e funeral director, page 5 should be detach	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached
death. Page 6 may be retained by the hos	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp

STATE	0F	MARYLAND	1	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYG	IEN
		C	E	RTIFICATE	OI	F DEA	ГН		REG.	NO.

	1 - FOR STATE OF MARYLAI REGISTRAR		TMENT OF H		MENTAI	HYGIEN	E		U 1 4/ 64
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE	OF DEATH			3. TIME OF DEATH
	Garnet Roy WELLER, Sr.				MONTH	-070		EAR	3:44 DM
		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	_	OF BURTH	0		PLACE (State or Foreign
		69 YRS.	MONTHS DAYS	HOURS MIN.	(Month	. 15,19		Country	
	9e. FACILITY NAME (# not institution, give street end number)	7				.13,19			-
œ		,		R LOCATION OF DE	HTA		9c. COUNTY		
ᅙ	112 West Franklin Street, Apt.	3	над	erstown			was	nıı	ngton
ည	10a. STATE 10b. COUNTY	10c, CITY	r. TOWN OR LOCAT	ION					10d. INSIDE CITY
DIRECTOR	Maryland Washington		Hagers	town					LIMITS? 1 X YES 2 NO
	10e. STREET AND NUMBER			ZIP CODE		7	40a CITIZEN		HAT COUNTRY?
R	112 West Franklin St., Apt. 3		1.0	2174	0		log. Offizzin	USA	112
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U		1 10 1110 1000						
5	1 Never Married 2 X Married FORCES? 1 X YES	2 NO		ENGENT OF HISPAN city Cuben, Mexica			or No- 14.		American Indian, White, atc.
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATE	ES	1 TYES	2 NO Specify	/:		_ L	Specify	white
E	15. DECEOENT'S EDUCATION	16a. DECEDENT'S	USUAL OCCUPATIO	N	166	KIND OF BUS	INESS/INDI IS:	TRV	WILLEC
	(Specify only highest grade completed)	(Give kind of w life. Do NOT us	vork done during mo:	at of working	100.	Kill Of BOS			
2	Elementery/Secondary (0-12) College (1-4 or 5 +)		none			n	one		
COMPLET	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	MF (First A	Aiddle Maiden	Sumame)		
	Martin L. Weller Sr.					M. St			1
BE	19e. INFORMANT'S NAME (Type/Print)	19h MAILING	ADDRESS (Street a	nd Number or Rural F	Snuth Niumh	ner City or Town	State Zin Co	rfo.)	
2	Martin L. Weller - brother			ngton St				-	21740
	200. METHOD OF DISPOSITION 200 P		OF DISPOSITION (Na		OATI		CATION — City		
	1 Burlel 2 Cremation 3 Removal from State cemat	tery, crematory or of	wn Crema	tory 3	-1-9				Maryland
1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	7		D ADDRESS OF FA		_			
- 1	Son SIMM III	(1							d. 21740
_	Cow of runnie								10. 21/40
	23. PART I. Enter the disease, or complications that caused to ahock, or heart failure. List only one cause on each	the death. Do n ch lina.	ot enter the mo	de ol dylng, auci	h aa card	liac or respi	ratory srreat	,	Approximate interval Between
	IMMEDIATE CALISE (Final	-	7 0	1					Onsat and Death
	disease or condition resulting in death)	oleal	dataro	4104					60sec
	DUE TO (OR AS A C	CONSEQUENCE OF	7):						C-111
z	Sequentially list conditions, b. W. C.	1eusic	M						> 97.
Ĕ	if any, lasding to immediata	CONSEQUENCE OF	F):						1611
2	cause. Enter UNDERLYING CAUSE (Disease or injury	u co	mær						1048
Ë∥	that initiated events resulting in death) LAST	CONSEQUENCE OF	F):						
CERTIFICATION	d								
AL C	PART II. Other significent conditions contributing to death but	t not resulting i	in the underlying	cauae given in	Part i.	24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
O I						PERFOR	Y		AMAILABLE PRIOR TO COMPLETION OF CAUSE
					_	1 TYES 2	NO		OF DEATH?
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH VE	S D NO D	UNCERTAIN					1 YES 2 NO
CIAN:			TH (Check anly one)	OTTOLKIAII	· · ·				
SIC	EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Output		OTHER:	-11-	. 🗆	40. 41.			
H	27. MAINER OF DEATH 286. DATE OF INJURY	28b. TIM	4 Nursing Hom E OF 28c, INJ			CRIBE HOW II	VIURY OCCUR	ED	
_	1 Natural 5 Pending (Month, Day, Year)		URY WO	RK? 'ES 2 NO					
á	2 Accident Investigation 3 Suicide 2 Could get be 28e. PLACE OF INJURY -	- At home, lerm, a			28f LOC	ATION (Street a	and Number or	Aural A	oute Number
	3 Suicide 8 Could not be building, etc. (Specify determined	(y)	, , , , , , , , , , , , , , , , , , , ,			or Town, State)		10/0/	outo rumosi,
E	290. CERTIFIER								
OMPL	(Check only 1 CERTIFYING PHYSICIAN: 10 the best of my knowled								
8	2 MEDICAL EXAMINER: On the basis of examination	www.cr mveatigatio	ni, in my opinion, d	watti occured at the	ume, date	una piace, en	u due to the c	muse(e)	and menner ee stated.
BE	29b. SIGNATURE IND TITLE OF CERTIFIER			29c. LICENSE NUM	WBER		29d. OATE S	GNED	(Morth, Day, Year)
0	* Tower's			10001	20			3/1	177
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	TH (ITEM 27) (Type,	AGENS	TOWN, 1	MO	2170	to S	anc	tra Fowler
i	31. DATE FILED WAR 02 1999 32. REGISTRAR'S SIGNAL	TURE 4	Son u	1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month OZ Dev Veer KENNETH Ear1 99 0958 26 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BERLIN WORCESTER 7L HDSP/7 7. Age (In yrs. lest birthdey) HTLANTIC CHENER 19L If Under 24 Hrs. 8. Dete of Birth (Month, Dev. Year) Aug. 21, 1936 If Under 1 Yeer Months Devs 9. Birthplace (State or Foreign Country) 5. Social Security Number Deys 10 M 2□ F 273 32 1657 62 Tennessee Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Fauquier Paris 1 Yes X No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 10590 John Mosby Highway 20130 U.S.A. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status Bleck White, etc. XIX Yes 2 □ No If Yes, Give 1 Never Married 2 X Married 1 Yes XXNo Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementery/Secondery (0-12) College (1-4or 5+) Carpenter Construction 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Golden Daniel Webb Myrtle Ensor Reed 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kay F. Webb 10590 John Mosby Highway, Paris, VA 20130 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Durial 2 Cremetion 3 Removel from Stete Culpeper Nat'1. Cemetery 3/2/99 Culpeper, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Helsley-Johnson Funeral Home, Inc. M00522 306 Union St., Berkeley Springs, WV 23a. Pert 1 Samer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory en shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Finel diseese or condition resulting in deeth) KEW MINS Due to (or es e consequence of): SCVD EW YEARS Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 250 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 □ DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

ms 23a or 28a-f ahov

r than "natural", or items the Medical Examiner ma

Director

Funeral

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Maryland 21215-0020

altimore,

3 00PS 8 Publ

Pages 1 end 2 should be nent of Health end Mental

Department of Important: If

/Medical

Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Physician/Medical as

by

Completed

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Certification:

Medical

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director

certificata

After this funeral

24 hours efter deaf Funeral Director: To the Hospital or Atterwithin 24 hours efter dea To the Funeral Director completely filled in by the

Hospital or Attending Physician:

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

25. Wes case referred to medical 1⊠Yes 2□ No 27. Menner of Deeth

5 Pending Investigation 1 Naturel 2 Accident 3 Suicide 4 | Homicide

6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

28d. Describe how injury occurred

(Check only one) 29b. Signeture end title of certifier

29a, Certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

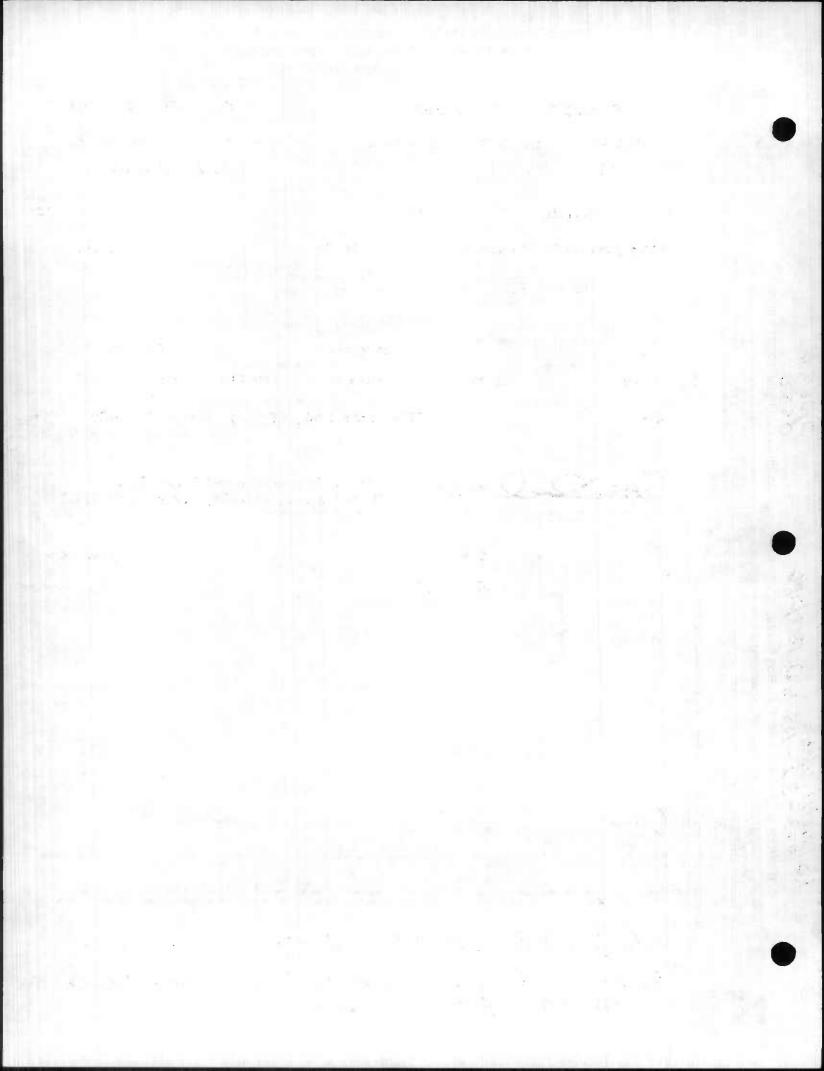
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

ZWORTH 3 1999

32. Redistrer's Signeture

203 SNOW ST. SAPOW HILL MD, 21013

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 20b, per F.D. Certificate of Death 3/1/99, Carroll County, wjl 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Natalie deRaismes Wood March /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 28, 1919 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1 M 20 F Months New Jersey 80 072-12-8107 Director **Usual Residence of Decedent** 10a. State 10b. County permit. Peges 1 and 2 should be flied within 72 hours efter death with the Marylan Department of Heelth and Mentel Hyglene.
Important: if Hem 27 is marked other than "natural", or Hema 23a or 28a-f show shiplury or other treumatic event, the Medical Examples must be notified at page. 10c. City. Town or Location 10d. Inside City Limits Westminster MD Carroll 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 2410 S. John Owings Road United States 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 20 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Marie Louise Noe Alfred deRaismes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L. Wood, Jr. / husband 2410 S. John Owings Rd, Westminster MD 21158 20b. Place of Disposition (Name of cemetery, cremetory or other place) 3/2/99 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Carroll Crematory Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility 91 Willis Street Myers Funeral Home Westminster, MD 21157 cher 23a. Hart1. Enter the thisease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, and or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final · Right hem is pheric cerebrovascular accident disease or condition resulting in death) Examiner fibrillation Examiner atrial physicien end the buriei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or es a consequence of) 987 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? To the Hospital or Attending Pl within 24 hours effer deeth. To the Funerel Director: After the completely filled in by the funeral 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 16 Rev 6/95

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrer's Signature

Hospital at 200 memorial Avenue, Westminster, M.D. 21157

, m. D.

June

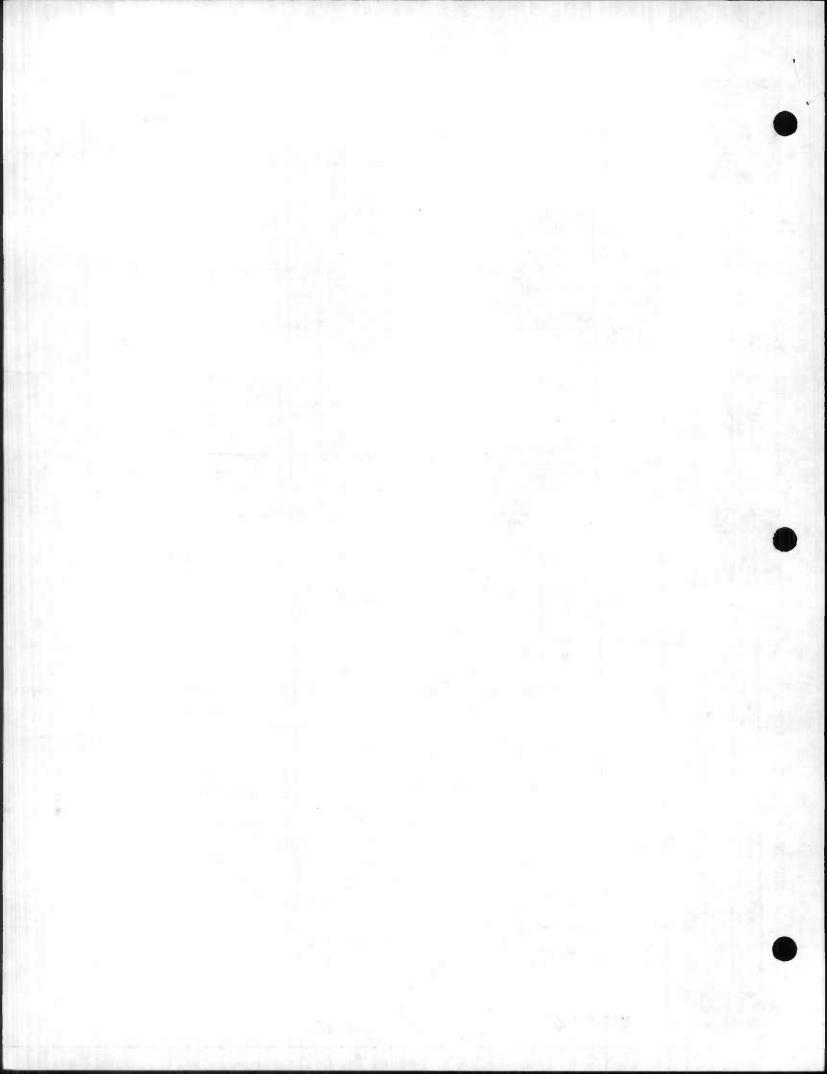
29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LISA Kim, Mp. at Carroll County General

00052479

29d. Date signed (Month, Day, Year)

March . 1 , 1999



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 26, per Phy. 3/1/99, Carroll County, wj1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 6:40 P.M. Yvonne H. Weekly 26, 1999 Feb. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, giva street and number) 4c. County of Deeth Examiner Columbia Howard 7344 Carved Stone if Under 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1□ M 2♥ F 78 Yrs. Director 155 01 3761 Feb. 26, 1921 N.J. Usuel Residence of Decedent Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or flems 23a or 28a-f show ury or other traumatic event, the Medical Examens must be nouned. Howard Columbia 1 ☐ Yas 2 No Md. Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21045 Funeral 7344 Carved Stone 12. Wes Decedent Evar in U,S.
Armed Forces?
1 ☐ Yas 220 No
If Yes, Give
Yaer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, Whita, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify:White p 3 □Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Receptionist USF&G 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Richard Doherty Elizabeth Wilson 19e. Informent's Name/Raletionship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7344 Carved Stone Columbia, Md. 21045 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Important: If ft any Injury or o once. 1 ☐ Burial 2 ☐ remelion 3 ☐ Ramovel from State Carroll Cremation Service 3/1/99 Hampstead, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funarel Sarvice Licensee 22. Name end Address of Fecility Sykesville, Md. 21784 rian 0) Haight Funeral Home & Chapel 23a. Pert1. Entar the disease, or complications the clused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat end Deeth **Physician** /Medical Immediate Ceuse (Finel essive dementio ears diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner sician and burial-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lesl Due to (or es e consequence of) attending physician for use as the buria Physician/Medical Due to (or es e consequence of): Yvonge Weekely 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. sata has been signed by the paga 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? this certificate has He H 1 Yes 201 No 1 ☐ Yes 2 ☐ No Physician: funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Normer (Spe 1 ☐ Yes 2 KNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of After Division Attending 1 Neturel 5 Pending 1 ☐ Yas 2 ☐ No To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: A completely filled in by the fi investigation death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner as steted.

Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29e. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end file of certified mo

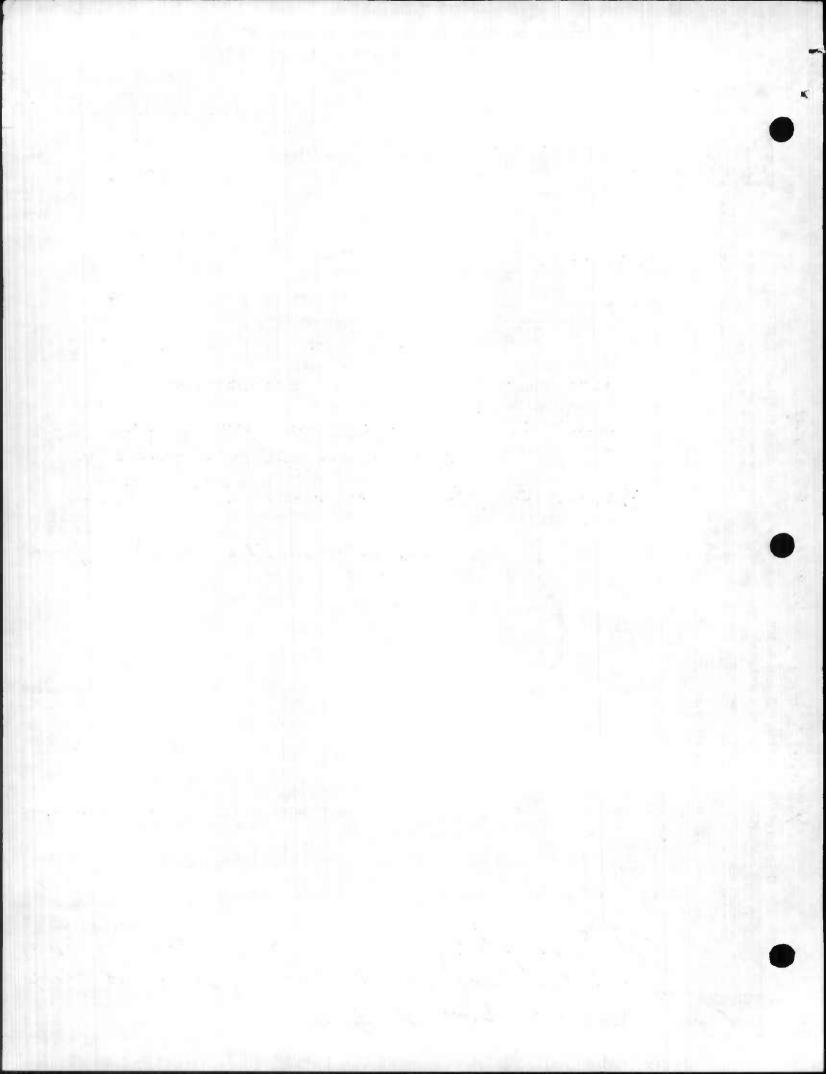
State Registrar

B 32. Registrer's Signature

30. Name and eddress of person who completed cause of death (Vem 23e) (Type, Print)

9

N. Charles St. Balto. Md ZIZOG



State of Maryland / Department of Health and Mental Hygiene Item 20b Per HOSP FilmG770 4-12-99 rja Certificate of Death 1. Decedent's Nema (First, Middla, Last) 3. Time of Death 2. Date of Death Month **Physician** 0330 aby 1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HEALTHCARE BALTIMEZ
If Under 24 Hrs. 8. Date of
Hours Min.
Hours Alin.
Hours Alin. A 6. Sex If Under 1 Year 5. Social Security Number 7. Age (fn yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 10 M 20 F Director Usual Residence of Dacedent 10a Steta 10h County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23s or 28s-f shov Examiner must be notified at Yes 2 No Director BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 151 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 ☐ Married 21215-0020 "natural", or 1 ☐ Yes 2 1 No Specify: Specify: BLACK If Yes, Give Yeer or Detes: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic avant, the Media page. Elementery/Secondary (0-12) College (1-4or 5+) aitimore. Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be LORI WHITE UNKNOWN 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Baltimore, MD 21229 900 Healthcare Caton ve 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata 20e. Method of Disposition 4-16-99 1 Burial 2 □ Cremetion 3 □ Removet from State Baltimore, MD Healthcaret 4 □ Donetion 5 □ Other (Specify) 22. Nama and Address of Facility 21. Signeture of Funeral Service Licensee hes St. A 9 900 , MD 21229 Caton Himore 23a. Part 1. Enter the disease or complications that caused the e shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediata Causa (Final PREMATURITY hours disease or condition resulting in deeth) Examiner Physician/Medical Examiner 1000 sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be assocuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) P.O. Box 68760, Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1□ Yas 2 No 3 Probably 4 Unknown Division of Vital Records. À 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 ☐ Yes 2 No certificate funaral director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Netural 5 Pending investigation after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier \$ 29b. Signatura and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) Susan M. Schogero MD - rearestologist February 23, 1999 D24590. 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Susan M. Schapiro MD St. Agres Hospital, 900 Caton Avenue, Baltimore MD 21229

State Registrar

DHMH 16 Ray 6/95

1900

31. Date filed (Month, Day, Year) WAR 1

ORIGINAL

32. Registrer's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Item 20b PEr HOSP FilmG770 4-12-99 rja Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Baby 0330 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner BALTIMORE HEALTHCARE AGNES If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) tf Under 1 Year Months Deys 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□ M 2/2(F Deys Director Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MI 1 Yes 2 □ No Director 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21229 136 CUIVER STREE USA "natural", or liams 23s. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. Wher then "natural", or the 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: altimore, Maryland 21215-0020 BLACK À 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If Itsm 27 is marked other I any Injury or other traumadic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WHITE LORI UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) St. Agnes Healthcare Baltimore, MD 21229 900 S. Caton 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4-16-99 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore Agnes Healthcare 5-1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses St. Agnes Healthcare 900 S. Caton Ave Ave 900 ,MD 21229 replications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part1. Enter the disease shock, or heart tailure. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PREMATURI Examiner Physician/Medical Examiner 060 physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 20 No of Vital or Attending Physicien; funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1.X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this. 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Division After 1 Natural 5 Pending investiga s effer des. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral D completely filled Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24590 Susan M. Dehogro MD-neonstologot February 23, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Susan M. Schapiro MD

MAR 1

- 1999

31. Date filed (Month, Day, Year)

32. Registrar's Signature

St. Agnes Hospital, 900 Coton Avenue, Beltimore MD 21229

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State	of Maryland	/ Departmen	t of Health	and Men	tal Hygiene	-

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State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 14, 1999 2:35 am GLORIA MARY ASIMENIOS March /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6906 Gunder Ave. Middle River Baltimore If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** Days Months Hours 1 □ M 2020 F 218-28-0452 Yrs Director 66 3, 1933 Maryland Feb. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Baltimore Middle River Maryland 1 Yea Z No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral 6906 Gunder Ave. 21220 U.S.A. filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Maritel Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: þ White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Hyglene. permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If Item 27 is marked other thy
any Injury or other trauments 7th Grade Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Walter Ziokowski Helen Krasnodemski 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Adele Asimenios / daughter 6906 Gunder Ave. Baltimore, MD 21220 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/18/99 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Connelly Funeral Home Of Essex 300 Mace Ave. Baltimore, MD 21221 23a. Part1. Enter the disease, or combo shock, or heart failure. List only lications that caused the death Dg not enter the mode of dying, such as cerdiec or respiratory errest, Approximate Interval Between Onset and Deeth re cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Severe Congestive Heart Failure 10 years Examiner Due to (or es e consequence of) Examiner Rheumatic Heart Disease physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the deeth certificate be Physician/Medical Due to (or as a consequence of): 88 attending esn 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 be detach 1 Yes 2 No 3 Probably 4 Unknown Liver Failure py 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed peed Seu page 2 The 1 Yes 2X No certificata 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide t☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e, Cartifier Medical 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D20907 March 15, 1999 Ralko 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) READ

State Registrar

31. Date filed (Month, Dey, Year) MAR 16

Marie D. Chatham, M.D.

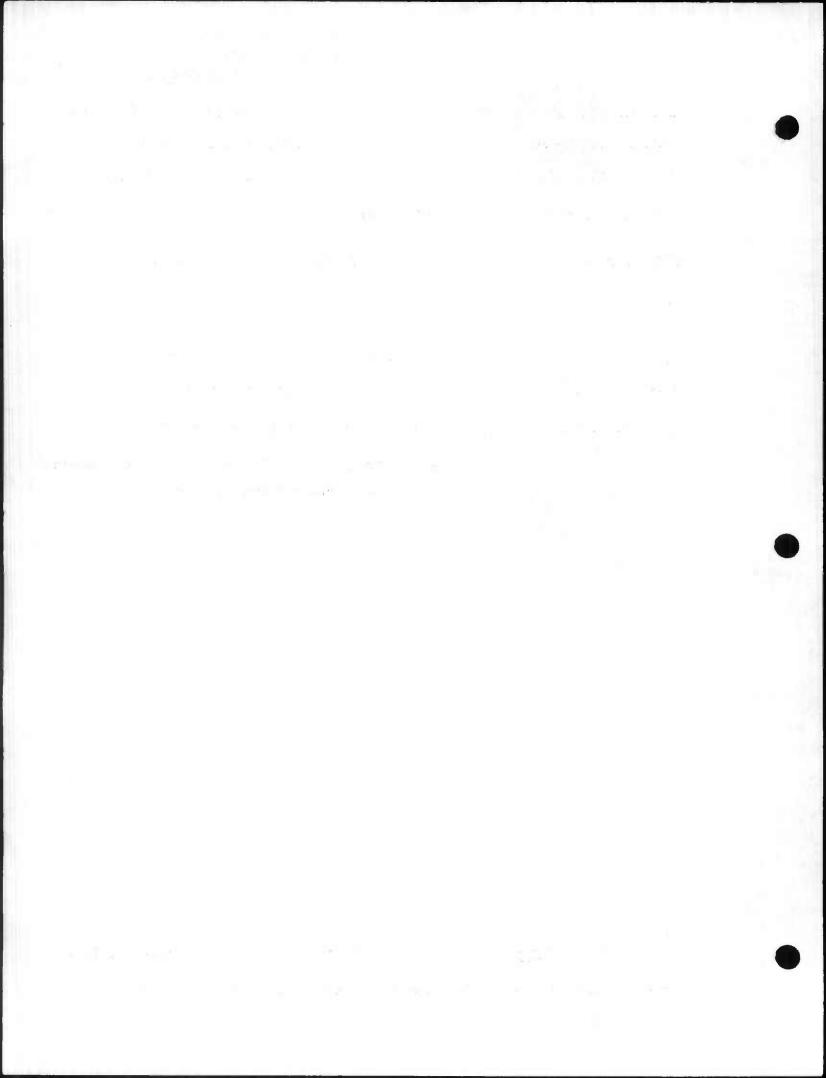
32. Registrar's Signeture

8114 Sandpiper Circle Baltimore, MD 21236

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician Sallie Anderson Carmen 12:15 pm March 12 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Knollwood Manor Nursing Home Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1 M 20XF 409-66-9200A Yrs 94 Director August 13,1904 Virginia Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Directo Anne Arundel Crownsville 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? na 23a or 694 North Riverside Drive 21032 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? or Rema Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after that of Health's and Mental Hybjans.

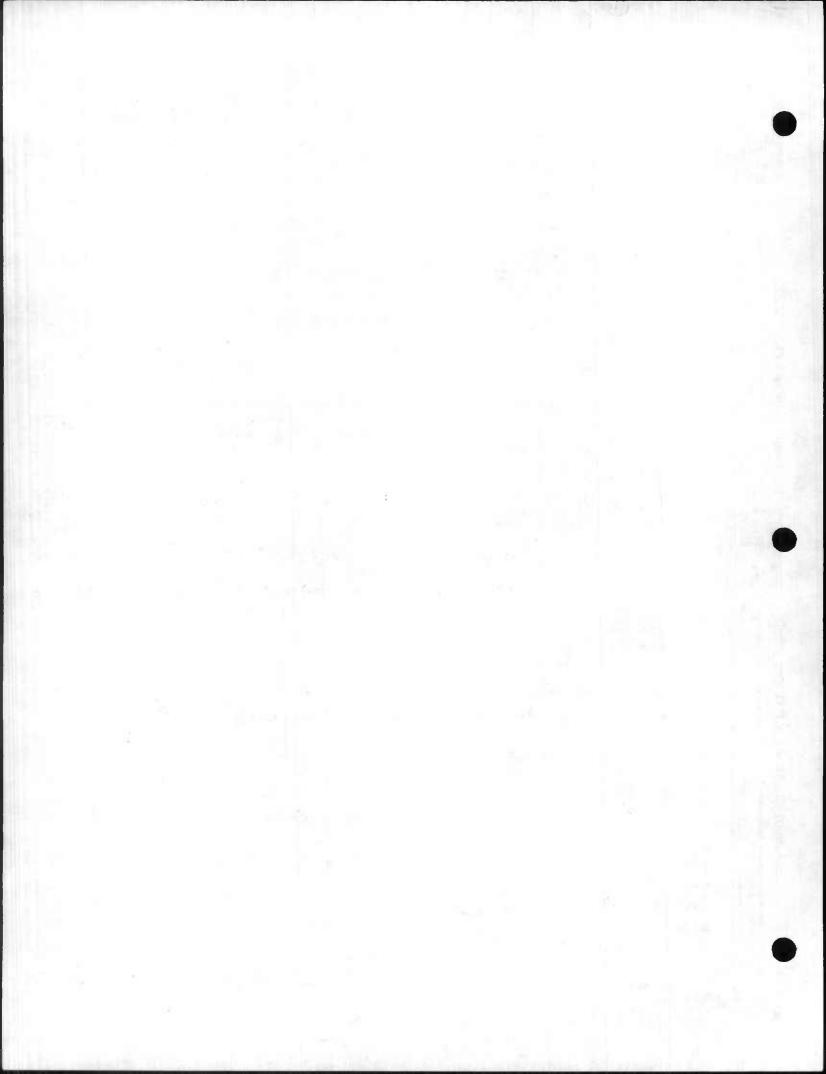
Interferent 27 is merked other than "naturel", or Resurt if Nem 27 is merked other than "naturel", or Resurt than traumatic event, the Medical Examinion ury or other traumatic event, the Medical Examinion 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Co-manager Retail/Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be John Cook Mary Willis Williams 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L.Aquilard (Son) 694 North Riverside Drive, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State Department of important: If any injury or Oak Hill Cemetery 03/17 Johnson City, TN 4 ☐ Donation 5 ☐ Other (Specify) turn of Fungral Service Licenses 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) cone hour Examiner Examiner cardiomyopa ears The lew requires that the deeth certificate be axecuted buriai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Records, P.O. Box 68760 tate has been signed by the attending physicien, page 2 should be detached for use as the buris Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 9/auc blindness 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 20 No Other: Certification: To Nursing Home 5 Residence 8 Other (Specify) this 28a. Date of Injury (Month, Day Year) Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending To the Hospital or Attending within 24 hours effer deeth.
To the Funeral Director: Afte completely filled in by the fun 1 TYes 2 No 2 Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of continue 41955 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd Arnold MD 21012 Clon ecca MD 1454 pel 32 Registrar's Signeture 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

MAR 1 6 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Deeth **Physician** Sacob Michael March 061 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AnneArunde M na polls
If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day. 6. Sex 1 D M 2 □ F 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplece (State or Foreign Country) **Funeral** Year) Days NA Months NIA March 11, 1999 50 Director Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avent, the Medical Examinar man be notified at Annapolis 1 ☐ Yas 2 ☐ No Director 1914 and Anne Armine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 02 21401 +merica miral Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, While, etc. Peges 1 and 2 should be filled within 72 hours effer on not of Health and Mental Hygians.
int: if Item 27 is marked other than "natural", or ha 1 Never Married 2 Merried 1□ Yes 218 No Baitimore, Maryland 21215-0020 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 hristine GAINETT Hlan -400 informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Bural Route Number, City or Town, Stete, Zip Coda) permit. Peges 1 and 2 a Department of Health or Important: If Nem 27 Ia sny Injury or other trau page. 2140 rarent Alan Admiral 15, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery or other p Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Cremator 03/16 4 Donation Metro 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or four plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 50min Examine Examine ettending physician and for use as the burlaf-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yes 2E No À 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? paga 2 s 1□ Yes 200No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA this s funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attanding within 24 hours eitar daath.
To the Funeral Director: Afta completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) To the I 29b. Signature and title of continue 29c. License numbe 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

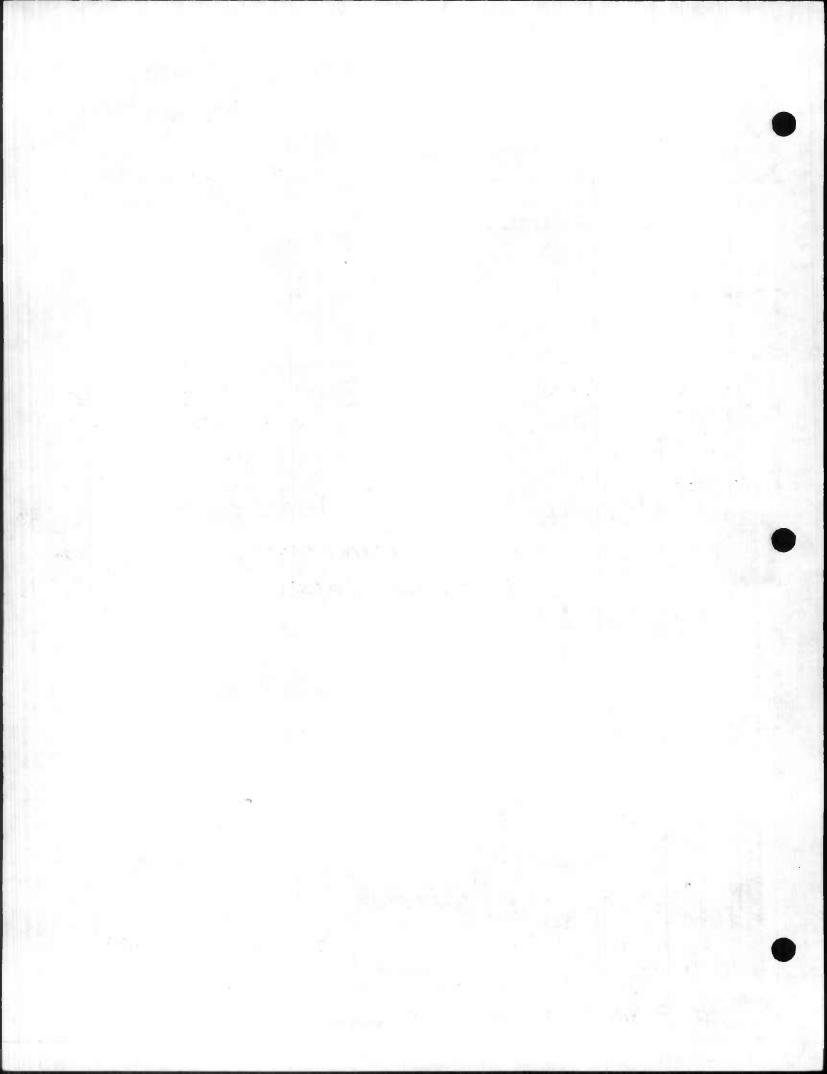
Registrar

31. Date filed (Month, Day, Year)

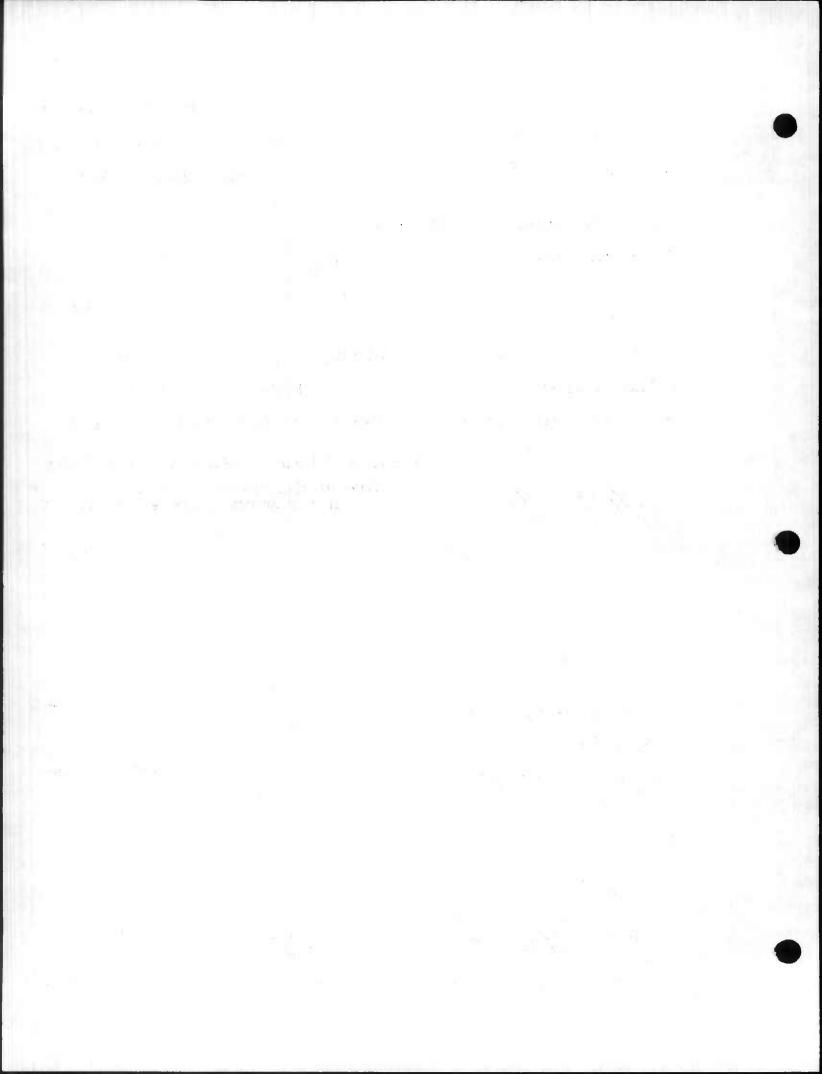
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Registrar's Signeture

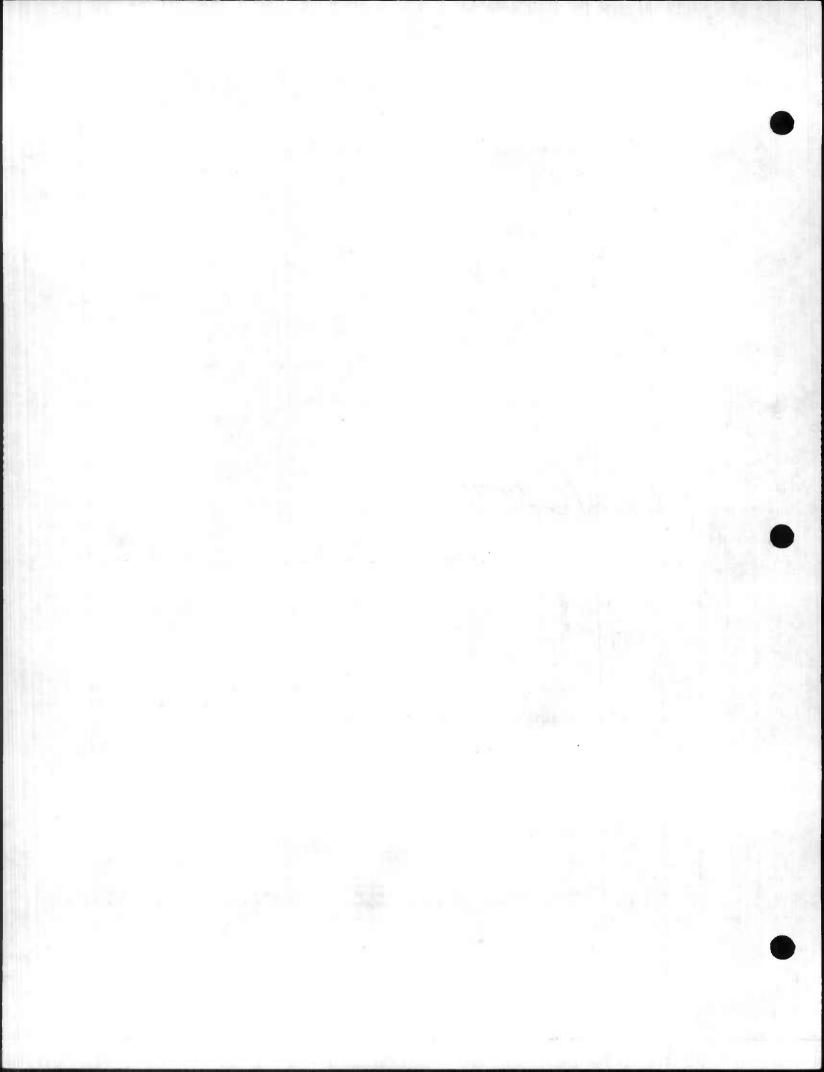


			Certificate of Death Reg. No.
	Physici /Medi		1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey Yeer EMMA G. BAKER 3. Time of Deeth Month Dey Yeer MARCH 10, 1999 4:35 PM.
	Examir Funeral Director	ner	4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 4c. County of Deeth 4c. County of Deeth 4c. County of Deeth 4d. County o
	with the Manyland a or 28a-f show Lbe notified at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Anne Arundel Baltimore 10ve 201 No.
	h with the 23s or 28 ist be not	al Director	10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5100 Fourth Street 21225 U.S.A.
020	hours after death with the Maryla uret, or ferms 23s or 28s-f shot at Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes, Specify: 17. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)
21215-0020	swithin 72 hours plene. r than "natural", the Medical Ext	Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) 7th 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. No Business/Industry 16c. Saleslady 17vin's
Maryland	should be tiled of Mental Hyg marked other matic event,	To Be C	17. Fether's Neme (First, Middle, Last) William Neisser Florence Whittington
100	and 2 sho saith and h 1 27 is ma er trauma		19e. Informent's Name/Relationship (Type, Print) Terri Jarman (Grand Daughter) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5100 Fourth Street Baltimore, Maryland 21225
Baltimore	Pages 1 mant of He ant: If Ben ury or oth		20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) Glen Haven Memorial Park 3/13/99 Glen Burnie, Maryland
Balt	permit. Pa Departmen Important: any injury once.		21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility
	Physician		MCCUITY-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 Approximete Intervel Between Onset and Deeth
	/Medical Examiner	er	Immediate Cause (Finel disease or condition resulting in deeth) Bue to (or es e consequence of):
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P.O.	t the d by the teched	/ Physician/M	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death of
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Vital R	The ete h page	Be Com	25. Was case referred to medical exeminer? 26. Plece of Death (Check only one)
of	Phys r this rai di	၉	27. Menner class Hospital: Inpatient 2 ER/Outpetient 3 DOA Other: Nursing Home 5 Residence 8 Other (Specify) 27. Menner class See. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work? 28c. Injury et Work? 1 Yes 2 No
Division	Hospital or Attending 24 hours efter death. Funeral Director: After stely filled in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State)
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)	6 % P 8		296. Signature and title of sentillar 296. License number 296. Dete signed (Month, Dey, Year) 297. Signature and title of sentillar 208. Signature
	Sta	to	30. Name and eddress of person who completed cause of deeth (Nem 23a) (Type, Print)
	ાત Registr	-	MAR 1 6 1999 1. Aprel 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q

	Decedant's Nama (First, Middla, La	od)	Ce	rtificate of	Death		Reg. No.	0.7			
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/Medical	Earl Henry Bradshaw, Jr. 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or L						-	1999 09:07			
Examiner	, ,				4b. City, Town, or L	ocation of Death 4c. County of Death					
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n 72 hours after death with the Maryland *natural*, or flams 23a or 28a-f show added Examiner man be publised at leted by Funeral Director	MD NA		Baltim					1 Yas 2			
	10e. Street and Number			10f. Zip Coda			10g. Citizen of W	hat Country?			
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eme Fr.	11. Marital Status	12. Was Decedant Ev Armed Forcas?	ar in U,S. 13.	Was Decedant of H	lispanic Origin? (Sp an, Mexican, Puarto	ecify Yas or No- Rican, atc.)	14. Race	- American Indian, , Whita, atc.			
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Depart Depart Import any Inj ans Inj		(Pass	9nn	z. Nama and Addra	Ba	ltimor	e, Mary	yland 2120			
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filcate be executed 3 physicien and as the bunal-transit edical Examir	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of):										
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es thet the deeth certificated by the attending be detached for use as by Physician/Me	Diastolic Dysfunction, Coronary Artery Disease,						1 Yes 2 No 3 Probably 4 Unknow				
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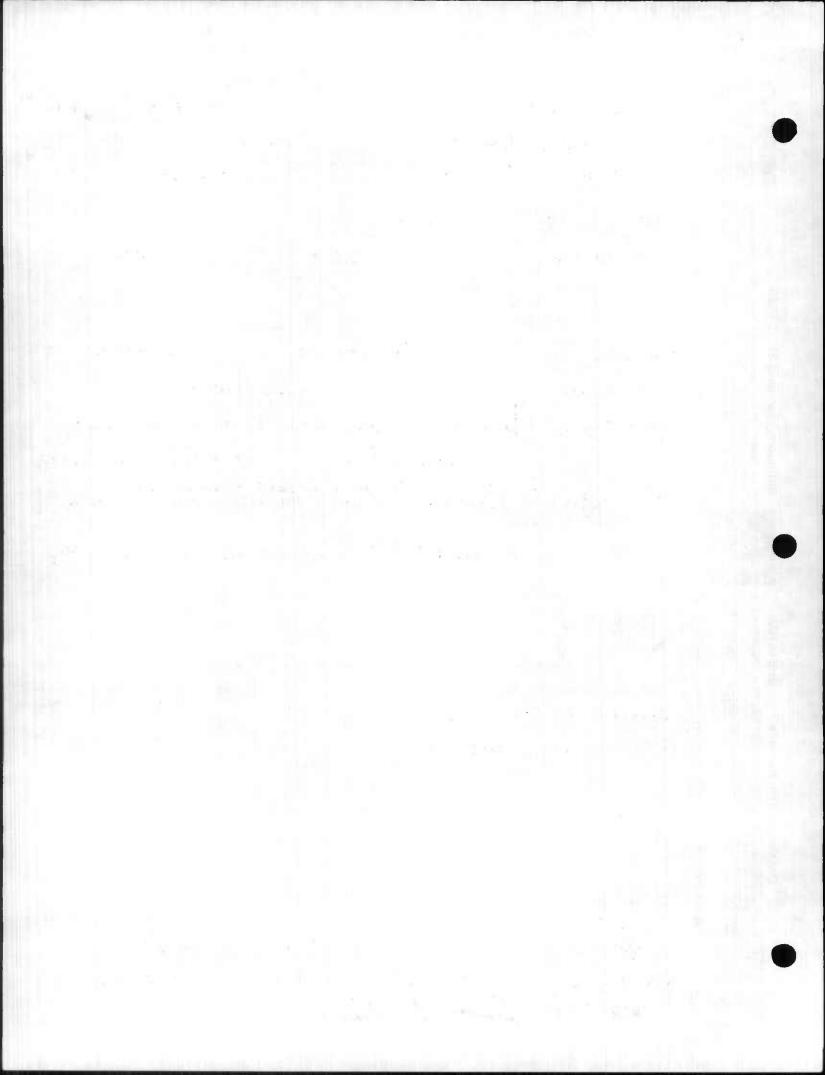


Please Type or Print in Black indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day **Physician** An 4:15 SHIRLEY BECKETT 03-07 - 99 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN BALTIMORE NIA HOSPITAL Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** 1□ M 2 F Months Davs Hours 215-14-9478 Yrs. mo Director Usual Residence of Dacedant Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heelth end Mental Hygiene. 10d. inside City Limits 10e State 10h County 10c. City. Town or Location in end Mental Hygiene. 7 is marked other than "naturel", or frems 23a or 28a-f show traumstic event, the Mexical Examiner must be notified as 1 Yes 2 No BALTIMORE Director NIA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KEVIN KOAD 812 21229 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: by BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion
(Giva kind of work done during most of working
iffe. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elemantary/Secondary (0-12) LRESSER COSMOTOLOGY 10 TH GRADE 18. Mothar's Name (First, Middle, Maidan Sumeme) 17. Father's Name (First, Middle, Last) Be JAMES BROWN GLADYS HARRIS 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) permit. Pages 1 and 2 s Department of Heelth er Important: If Item 27 is eny Injury or other trau BECKET KOAD, BALTIMORE, MD. 21229
Data 20c. Location - City or Town, State HUSBAND JAMES 812 KEVIN 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Metbód of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State JARRISON FOREST 3-12-99 4 ☐ Donetion 5 ☐ Other (Specify) (WINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart with List only one cause on each lina. BALTO. MD. 21229 **Physiclan** Cardio vascular /Medical Immediete Cause (Final Atherosclerat disease or condition rasulting in death) Examiner Examiner physicien end the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaase or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, **Physician/Medicai** Due to (or es e consequence of): signed by the at Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contributa to the ceuse of death? 1 Yes 20 No 3 Probably 4 Unknown Chronic Mullitis. g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy Cerebro vascular Disease this certificate has 1 Yes 2 No 1 TYes 2 No Hospital or Attending Physician: Be 25. Was cese raferred to medical examiner? 26. Pleca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3200A funeral 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation 1 Naturel s after deeth. 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcida To the Mospital of within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data end place, end due to the cause(s) and manner stated. 29a. Certifian Medical 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of sentifiar 5 30. Name and eddress of person who completed causa of daath (Item 23a) (Type, Print) PEB 4300 N. Charles St. Baltimore Vissing 21218 MD

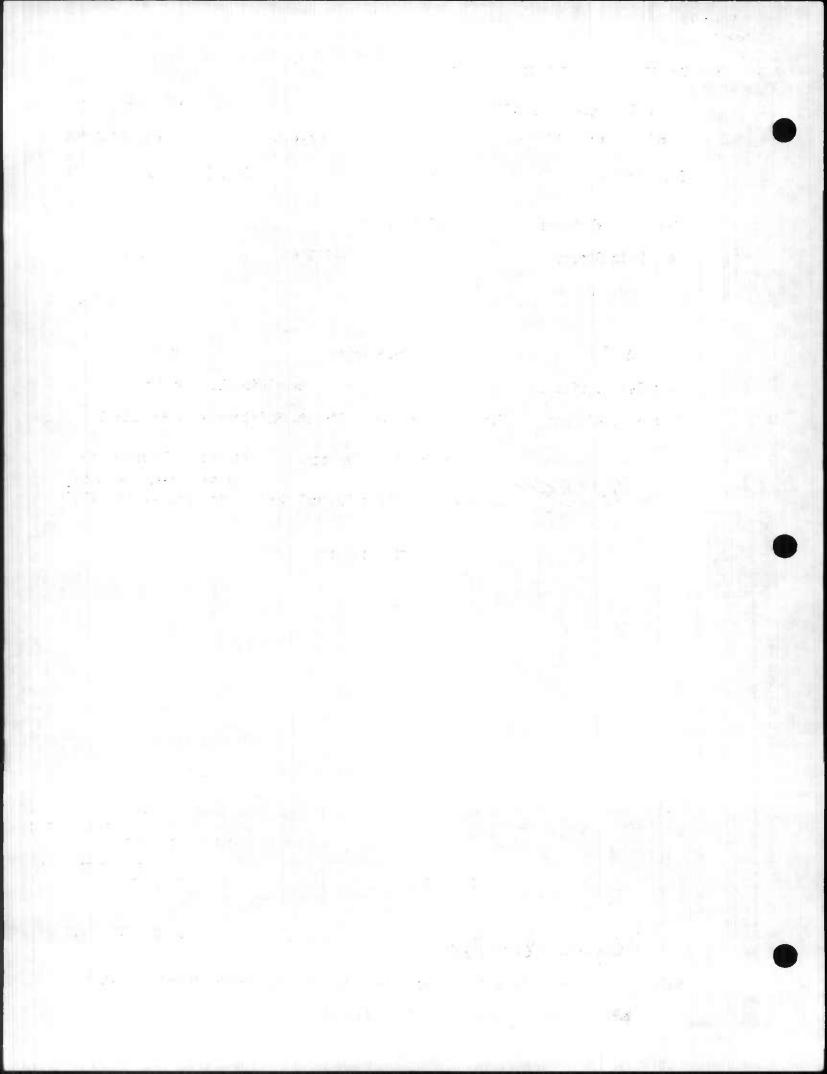
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State Registrar 31. Date filed (Month, Day, Year) MAR 1 6 1999

32. Registrar's Signature



AVID LEE AVID LEE AVID LEE AVID LEE AVID LEE AVID LEE AVITRAK Security Number 62-8112 Sidence of Decedent 10b. County Baltim Balti	BISSETT Give street and nut STATION 6. Sex 1\(\) M 2 \ F Ore t 12. Was Dece Armed Fo 1 \ Yes If Yes, Give Year or D college (1 2 Last) Sett Sett Sett Sett Sett Sett Sett Bip (Type, Print) tt Wi 3 \ Removal from Secify) Secify	7. Age (In yrs. 2006.) 7. Age (In yrs. 2006.) 10c. Ci Redeni Ever in U 2007. 11-4or 5+) 1-4or 5+)	144 Yrs ity, Town or eistel J.S. 1 16a. De (G) (G) (G) To 19b. M 45 Place of Dicemetery, udon	r Location rStOWN 10f. Zip 13. Was Deced If Yes, spec 1 Yes 2 eccedent's Usua sive kind of wor e. Do NoT us eChnici leiling Address 2 Main isposition (Nen cremetory or of Park Ce 22. Name and	Code 2 Days Code 2 No All Occupric done is retired an Occupric done of ther placement and Addre	Linthi If Under 24 Hours 1136 Hispanic Originan, Mexican, Specify: Dation during most of during most of during most of the d	n? (Specify Yes or Puerto Rican, etc.) of working s Name (First, Midline N. or Rural Route Nucleisterst Date 3/19/9 1182 me Reis	Birth ANNE Birth Pay, Year 1955 10g. Citizen of U. No- 14. Rac Bla Specifi 16b. Kind of B B G & Meiden Sumer Eigenbro mber, City or Town Own, MD 20c. Location Baltim 4 Reister terstown,	9. Birthplece (State or Foreign MD 10d. Inside City Limits 1 Yes 2 No What Country? S.A. ce - American Indian, lock, White, etc. White Business/Industry E Me Country White Country Country S.A. Country White Country Country White Country Country Country White Country
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Nama (First, Middle, Last) 6:20 PM GONO March 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Himore Blyd)alther 5. Sociei Sacurity Number 6. Sax 10X M 2□ F If Under 1 Yeer 9. Birthplace (State or Foreign Gountry)
111380ULI 7. Age (In vrs. last birthday) 8. Deys Hours Min 495-26-5274 Usuel Residence of Decedent Yrs. 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ltimor 1 ☐ Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Haca - Amarican Indien, Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Maritei Stetus Bieck, Whita, atc 1 ☐ Yas 2 No If Yes, Give Yeer or Detes: 1 Navar Married 2 Married Specify: White 1 □ Yes 2 000 Specify 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Security National College (1-4or 5+) Eiementary/Secondary (0-12) ency MATHEMATICIAN 17. Eathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumerna) aymono PN 19e. Informant's Neme/Reletionship (Type 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 322 Baltimore 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) March 12 20c. Locetion - City or Town, Stete Funeral Chapel 21. Signetura of Funerel Service License 22 Name and Address of Facility Vans 23e. Part T. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Md 21234 Approximete Intervei Between Onsat and Deeth immediate Ceusa (Finel disaese or condition resulting in deeth) 1977 20V Due to (or es e consequence of) Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Due to (or es e consequence of) 23b. Did tobacco use contributa to the cause of death? Pert II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings eveilable prior to completion of causa of death? 24e. Wes en eutopsy 1 Ves 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4□ Nursing Home 5 Assidence 6 □Other (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3□ DOA 28a. Dete of injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? 1 Naturei 5 Pending 1 ☐ Yes 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piace of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner as steted. (Check only one) 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours efter death To the Funeral Director: / completely filled in by the f

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

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Funeral

Director

the Meryland

Peges 1 and 2 should be filed within 72 hours efter death with the Merylen nent of Health end Mentel Hygiene. Interest of them 23 or 28a-1 ehow ant: if Item 27 te marked other than "natural", or items 23a or 28a-1 ehow ary or other traumatic event, the Medical Exerciter that he nouted at

Important: if them 27 le n any injury or other traum once.

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Certification:

Medical

Baltimore, Maryland 21215-0020

State

Registrar

DR. ALAN HALLE 31. Deta filed (Month, Dey, Year)

29b. Signeture and title of certified

29c. License number

BLUD

29d. Date signed (Month, Day, Year)

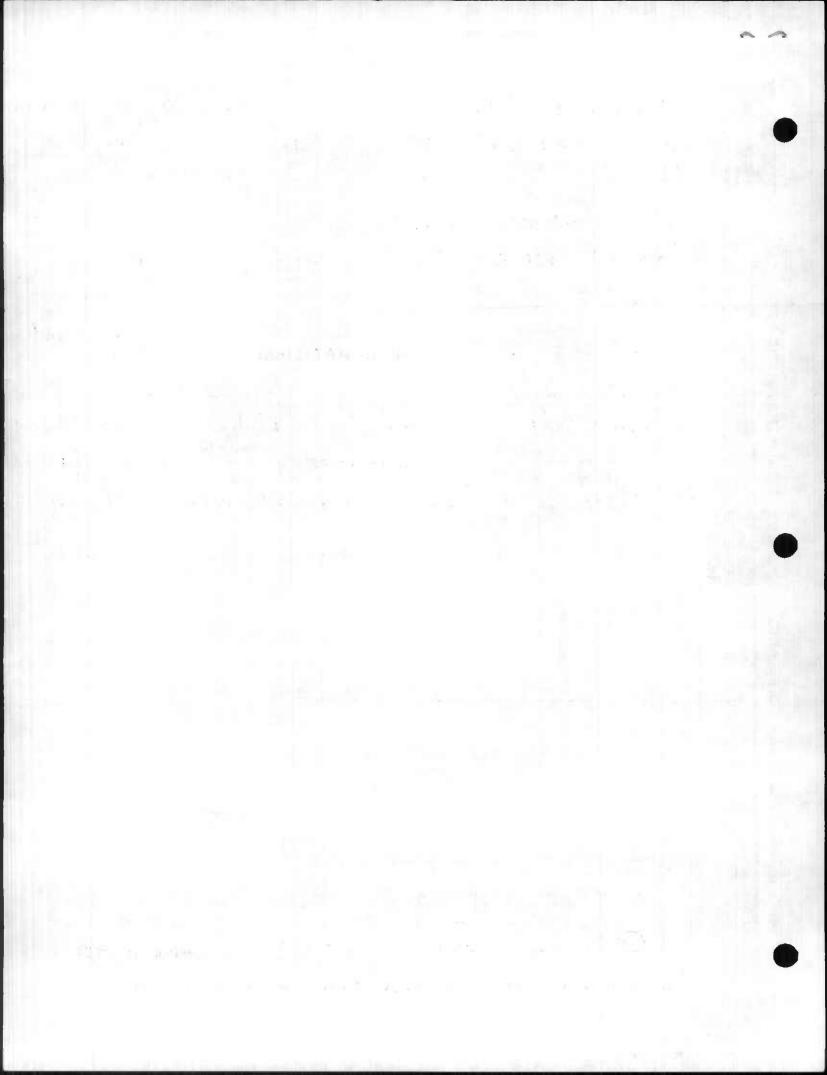
30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

MAR 1 6 1999

4920 CAMPBELL WHITE MARSH, MD

MARCH

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 15, 1999 9:05 A.M. MYRTLE LOUISE BENDER 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Millersville KNOLLWOOD MANOR NURSING HOME ANNE ARUNDEL 8. Date of Birth (Month, Dey, Yeer) FEB. 13, 1901 9. Birthplace (Stete or For Country) PENNSYLVANIA If Under 24 Hrs. 5 Social Security Number If Under 1 Year 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthdey) Months 10 M 20 F Days Hours 187-24-3870 98 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐ No Glen Burnie MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21061 UNITED STATES 18 Eugenia Ave. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 A No Specify: Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) DO NOT use ratired) HOMEMAKER Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 8 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumama) HERMAN EDWARD STUCK ELLA REBECCA PRITZ 19b. Mailing Address (Street end Number or Rural Route Numbar, City or Town, Steta, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) Lazzette Beachley/Daughter 517 Cleveland Rd. Linthicum, MD 21090 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Mar. 18 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Inter.Order of Odd Fellows 4 ☐ Donation 5 ☐ Other (Specify) 1999 Berlin, Pennsylvania 21. Signal re of Funeral Service Licerse 22. Name and Addrass of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21061 Approximate interval Between Onset and Death Immediata Causa (Final Due to (or as a consequence of): Ceste lung Conges tion disease or condition rasulting in daath) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated execute. Due to (or as a consequanca of)

Physician /Medical Examiner

Physician

/Medical

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Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Modical Examinat must be notified at

other t

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Peges 1 end 2 should be filed within 72 hours efter or nent of Health and Mentel Hygiene. Int: If Item 27 Is marked other than "natural", or ite

Baltimore, Maryland 21215-0020

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Examiner cal

Division of Vital Records, P.O. Box 68760,

this or Attend efter death Director: 24 hours

> State Registrar

an/Medi	resulting in death) Last	d.	or as a consequence	or):			
y Physician/M	Part II. Other significant conditions co	ntributing to death but not rai				23b. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Wunknow.
Completed by	Congestion	heart of	Lailme	, ,	bric	24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of ceuse of death?
Be (25. Was case referred to medical				26. Place of De	ath (Check only one)	
10	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	BER/Outpatient 3E	DOA	Other: 4X Nursing	Home 5 ☐ Residence 6 ☐ Ott	her (Specify)
atlon:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Data of Injury (Month, Dey Year)	28b. Time of injury	28c.	injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred
Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, street, fairly)	ctory, of	ffice	28f. Location (Street end Num City or Town, Stelle)	ber or Rural Route Number,
edical (e, and due to the cause(s) and murrad at the time, date and place,	
ž	20h Signature and title of certifier			29c 1	icense number	29d Date signs	ed (Month Day Year)

29c. License number

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march 16, 1989

29d. Date signed (Month, Dev. Year)

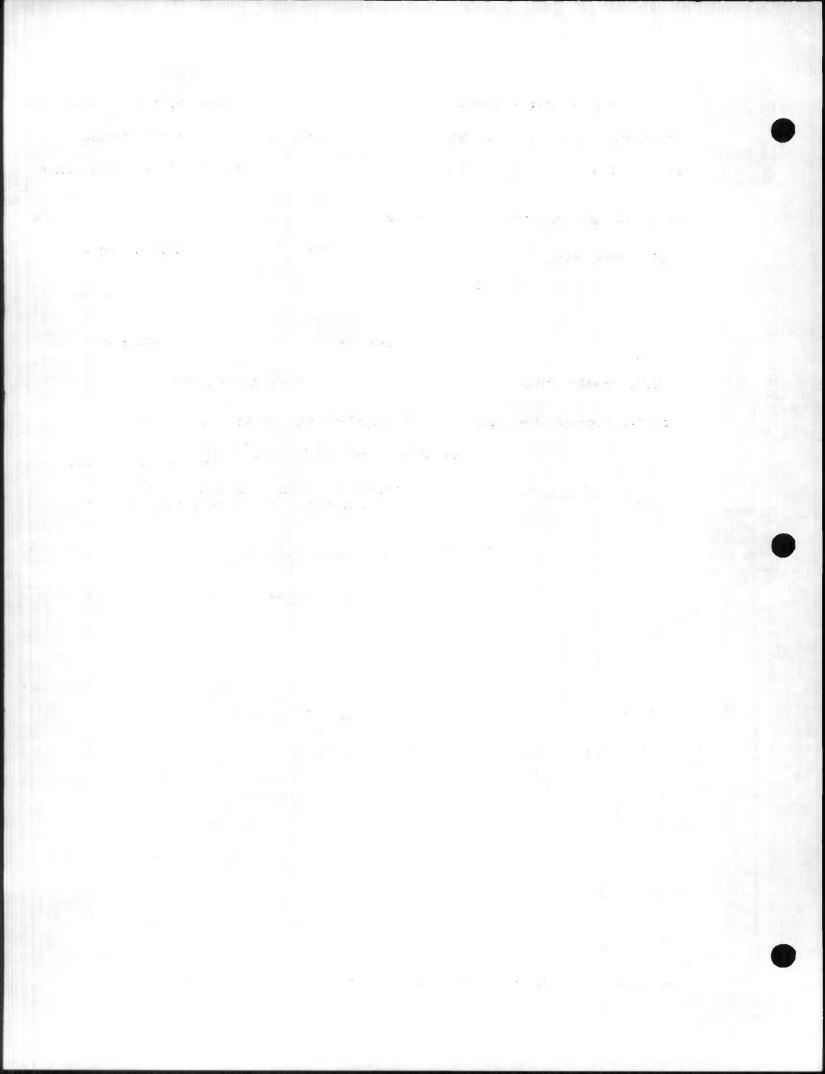
VI MD 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

PO HUNG, M.D. 1916 S. CRAIN HWY. SUITE 8 GLEN BURNIE, MD 21061

31. Date filed (Month, Dey, Year) 32. Registger's Signature MAR 1 6 1999

29b. Signature and title of certifier

within 2.



Examiner Box 68760. P.O. Division of Vital Records.

Examiner Physician/Medical Completed by or Attending Physician: Medical Certification: To 24 hours efter death. filled in by Hospital

Physician

/Medical

Examiner

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r than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at

death

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permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygiens Important: If Nem 27 is marked other that any injury or other traumation...

Physician

/Medical

Baltimore, Maryland 21215-0020

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laura

29a. Certifier (Check only one)

Registrar

within 2 To the \$

DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year) MAR 16

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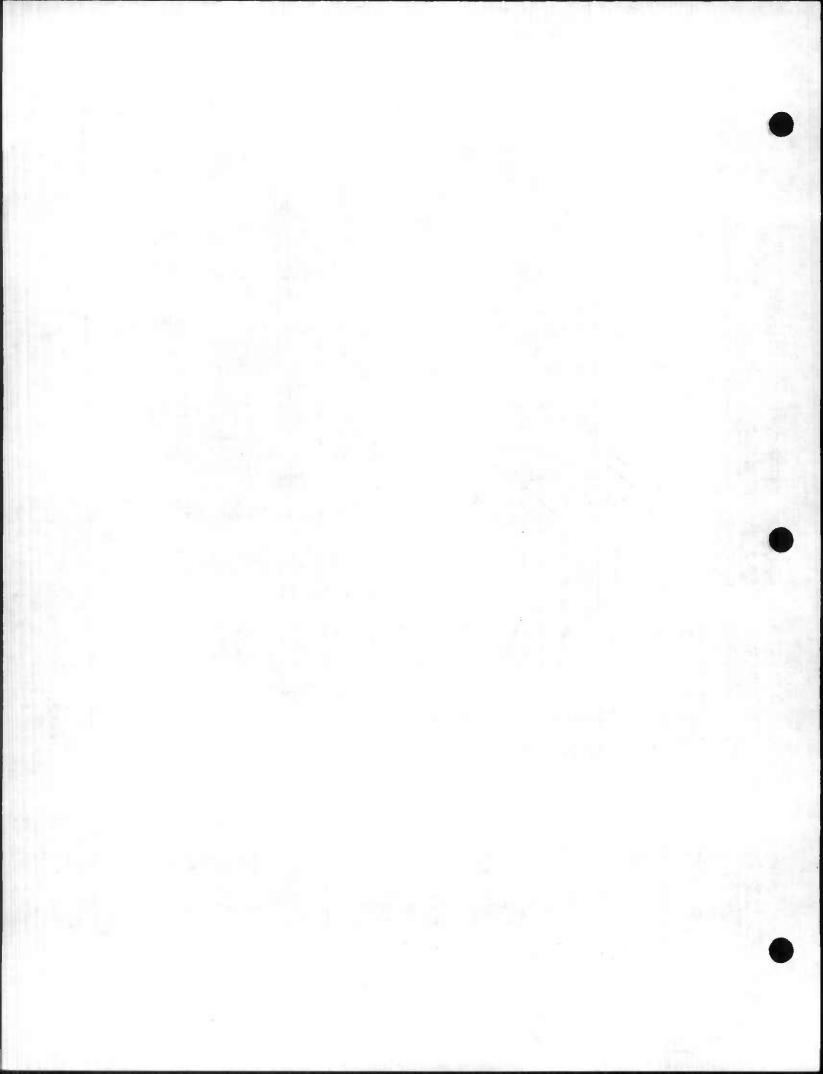
Falls Rd Lutherville MD

11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

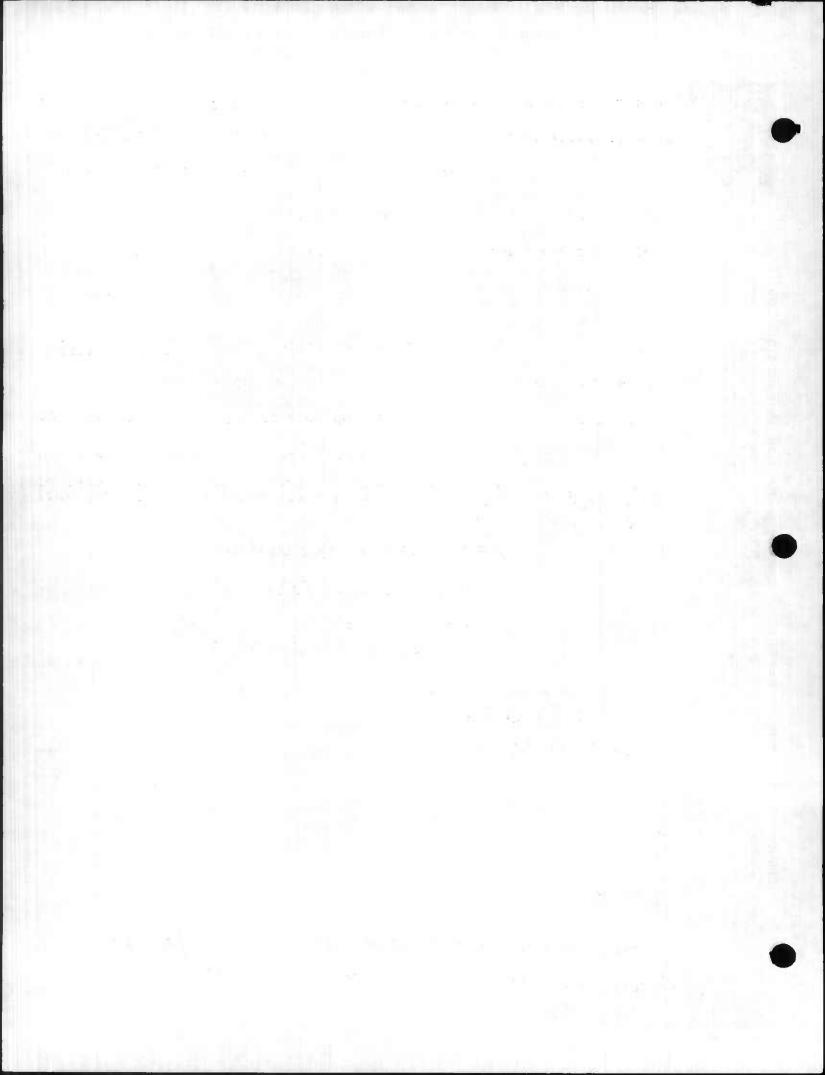
29c. License number

29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygier 9 08 | 69

				Certificate	of Death	R	Reg. No.			
	Physician	Decedent's Neme (First, Middle, La ADA PATRICIA		ILEY		2. Dete of Dee	eth	year 99	3. Time of Deeth 2:00pm	
	/Medical Examiner	4a Fecility Neme (If not institution, gir 2206 LUKEWOOD		es.)	4b. City, Town, or WOODL	Location of Deeth	4c. County	of Death	? E	
	Funeral Director	216-24-6445	Sex 1□ M 2KD F 7. Age (In yrs. 71	Yrs. If Under 1 Months	Year If Under 24 Hrs Deys Hours Min		, Year) 1927	Count	leca (Stete or Foreign try)] 1 a n d	
	the Meryland 28a-1 show noulfied at	Usuel Residence of Decedent	10c. Ci	ity, Town or Location WOODLA	WN			10	0d. Inside City Limits 1 ☐ Yes 2 🖾 No	
	D P o	10e. Street end Number 2206 LUKEWO	OOD DRIVE	10f. Zip C	21207	1	10g. Citizen of Whet Country? $U \cdot S \cdot A \cdot$			
5-0020	hours effer deeth hours effer deeth urel; or items 23	11. Marital Status 1 Never Married 27 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	J,S. 13. Wes Decede If Yes, specif	nt of HispenIc Origin? () y Cuben, Mexican, Puel I No Specify:	Specify Yes or No- to Rican, etc.)	14. Red Blac Specify	a - America ck, White, e : B1		
5-0	72 ho	15. Decedent's E (Specify only highest gr	ducation ede completed)	16a. Decedent's Usuel (Give kind of work	Occupation done during most of wo	orking	16b. Kind of B	usiness/Ind	lustry	
2121	ed within 72 ho ygiene. her than "natur. rt, tre Modical Completed	Elementery/Secondary (0-12) 1 2 t h	College (1-4or 5+)	Claims Ac	16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Adjuster				curity ation	
land	be fill H d out	17. Fether's Neme (First, Middle, Last James Edwar				me (First, Middle, Orgia M		10)		
, Maryland	d 2 shoth end 7 is m traum	19e. Informent's Neme/Relationship William Bail			Street end Number or Fi					
Baltimore,	Peges 1 en ent of Heal nt: If item 2 iry or other	20e. Method of Disposition 1 ₭ Buriel 2 □ Cremetion 3 [4 □ Donation 5 □ Other (Speci	Themover from State	Plece of Disposition (Nemccemetery, cremetory or off ing Memoria	of erplace) 3/17/ al Park	9 9 Dete	20c. Location - Randa1		wn, Stete	
Balt	permit. Pe Depertmen Important: any injury	21. Signature of Funeral Service Lice	7 1 Quet		Address of Fecility O. DYETT LIBERTY H				OME, P.A.	
	Physician /Medical Examiner	23a. Ruft. Enfecthe disasse or construct of the construction of th	0.	ATTON					Approximete Interval Between Onset and Death	
	sit sit		b. PAR	or es e consequenca of):	5 DUSE	ASE				
68760,	certificate be executed rding physician and use as the bunel-transit	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of):								
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	The law age 2 pege 2					1 D Y	es 2000	10	Yes 20 No	
of Vital	ortific Be	25. Wes case referred to medical examiner?	Hospital:		Other	eath (Check only of				
of	this ald	1 ☐ Yes 2 ☐ No 27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)	ER/Outpetient 3 DO/	c. Injury et Work?	28d. Describe h	lence 6 Oth now injury occur		0	
Division	To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affer the completely filled in by the funeral Medical Certification:	1 SNaturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determined	n	Injury M nome, ferm, street, fectory,	1 ☐ Yes 2 ☐ No	28f. Location (S City or Tow	Street end Numi vn, State)	ber or Rure	ol Route Number,	
	Hospita 24 hours Funeral letely filled	29a. Certifier 1 Certifying P(Check only one)	hysician: To the best of my known the state of my known the sail of exeminating and manner stated.	owledge, death occurred e etion end/or investigation, i	the time, dete end plea n my opinion, deeth occ	e, and due to the curred et the time, c	cause(s) end m dete end place,	enner es st end due to	eted. the cause(s)	
	To the within To the compl	29b. Signeture and title of cartifier	and ATTERDAM	B-Ptysicing 29c.	License number		29d. Dete signe	od (Month,	Dey, Year)	
		30. Name end eddress of person who	completed cause of death, (Ite	m 23e) (Type, Print)	O MD,	MPH				
3	State Registrar	31. Dete filed (Month, Dey, Year) MAR 1 6 199	32. Registrer's Sign	eture ;	4					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Item:31 per V.R reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician p 6e Ccm 11:21pm /Medical March 09, 99 4e. Fecility Name (If not institution, give street end humber) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3813 Milford Avenue Baltimore If Under 24 Hrs. 8. Da 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Days Hours Min 1□XM 2□ F 72 Yrs. Director 238-32-4764 04 - 11 - 26NC Usual Residence of Decedent 10e. State 10b. County ns 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3813 Milford Avenue 21207 USA 12. Was Decedent Ever in U,S. Armed Forces?

1★ Yes 2 □ No If Yes, Give Year or Detes: items Was Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. the Medical Examiner 1 Never Married 2 Married 6 1□ Yes 2□ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black natural Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Engineer 12th Grade other 1 3yrs. Westinghouse 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be it of Health and Mantal If Item 27 is marked o Unknown traumetic Fannie Frazier 21207 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Dorothy Campbell 3813 Milford Avenue Baltimore, Maryland other 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, State 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department in Important: If any Injury or Garrison Forest VA Cem. 03-17-99 Owings Mills 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licanson 22. Name end Address of Fecility Baltimore, Maryland 21202 2 WM.C.March FH 1101 E. North Avenue emand moun 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest buniel-trer Due to (or es e consequença of) Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? pege 2 should Completed 24e. Wes en eutopsy performed? After this certificate has 1 Yes 2 2 No 1 Yes 2 No Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No nours efter death.

neral Director: After this y filled in by the funeral di 27. Menper of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation Injury 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours of To the Funeral D 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. Medicai 29e. Certifier (Check only one)

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Peges 1 and 2 should be

The law requires that the deeth certificate be executed

Box 68760

P.O. |

Records,

Division of Vital

Physician:

Attending

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21215-0020

Maryland

Baltimore,

Registrar

31. Dete filed (Month, Dey, Yeer)

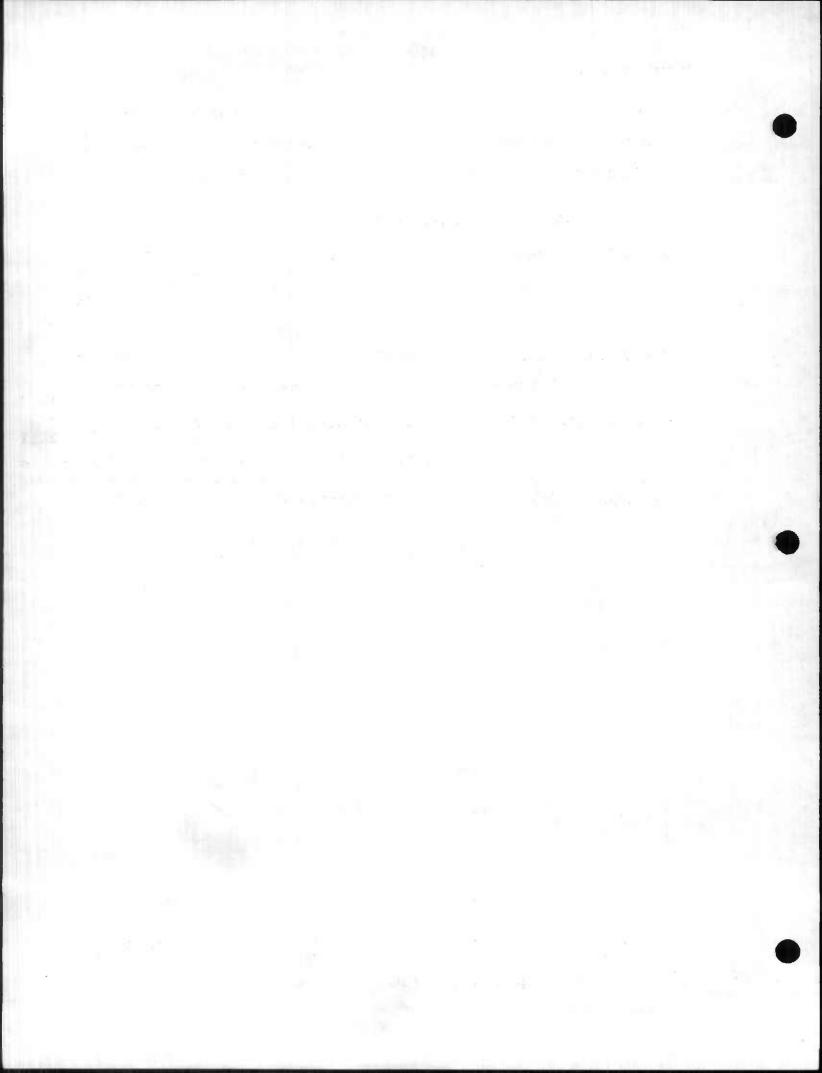
29b. Signature end title of cartifier

MD

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 222 32. Registrar's Signeture MAR 1

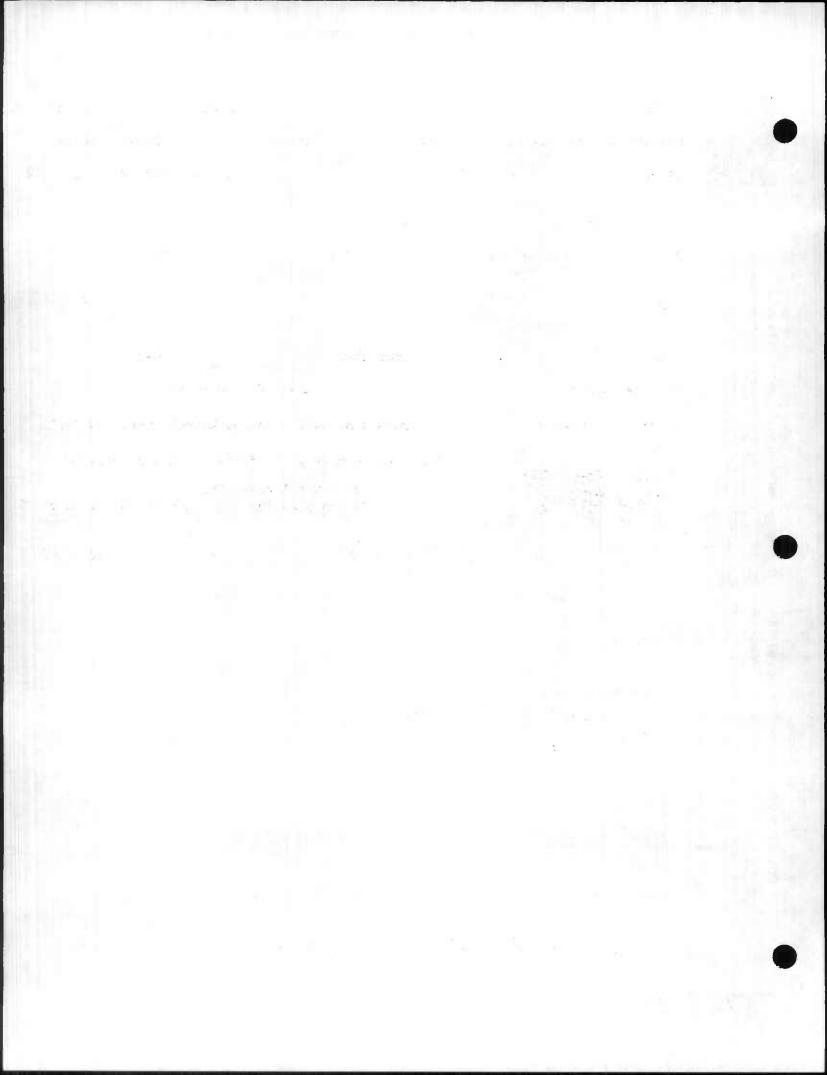
29c. License number

29d. Dete signed (Month, Dey, Year)



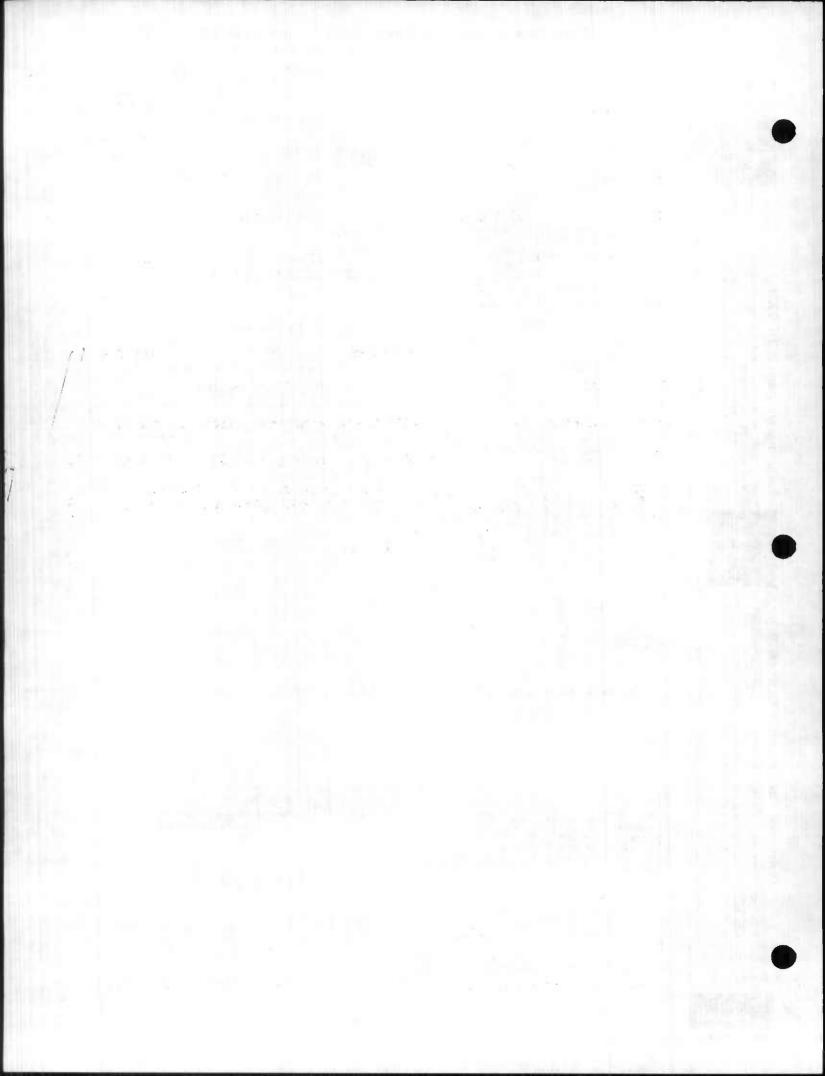
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		1. Decedant's Nama (First, Mid	dia, Last)					1	2. Data of Daat		Vaar	3. Tima of Death
8	Physician /Medical	Wylia Cerne										10:30 p.m
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L		Mariner Health					Laur	0.11		Pri		
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lar	0 % D .	William Manks					Anna	В.	Hollow	ay		
Maryland	2 should and Men is marked aumatic	19a. Informant's Name/Relatio	nshlp (Type, Print)		19b. Maili	ng Addrass (Stree	t and Numbe	er or Rural	Route Numbar	Month 13, 1999 10:30 p.m. arch 13, 1999 10:30 p.m. arch 13, 1999 10:30 p.m. 4c. County of Death Prince George Set of Birth Month, Day, Year) ar. 4, 1912 9. Birthplace (State or Foreign Country) ar. 4, 1912 10d. Inside City Limits 1 Yes aF No 10g. Citizen of What Country? USA Yes or No- 14. Race - American Indien, Black, White, atc. Specify: White 16b. Kind of Business/Industry Own Home st. Middle, Meiden Surmama) Holloway ute Numbar, City or Town, State, Zip Code) W. Laurel, Maryland 20723 ata 20c. Location - City or Town, State 8/99 Glen Burnie, MD Inc. Dad, Laurel, Maryland 20707 Approximate Intarval Batween Onsat and Death WECKS 24b. Ware autopsy tindings available prior to completion of cause of death? 1 Yes 2 100 3 Probebly 4 Unknown 24a. Wes en eutopsy parlomed? 1 Yes 2 100 1 Yes 2 100 10 Yes 2 100 1 Yes 2 100 11 Yes 2 100 1 Yes 2 100 25b. Rasidence 6 Other (Specify) Dascribe how injury occurred Location (Street and Number or Pural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 3 100 794 100 100 100 3 100 100 100 100 100 100 100 100 101 102 100 100 102 103 100 100 104 105 100 100 105 100 100 100 106 100 100 100 107 100 100 100 108 100 100 100 109 100 100 100 100 100		
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Baltimore,	permit. Page: Department of Important: If i	21 Signature of Funeral Service	e Licensea		2:	2. Nama and Addr			т., .			
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12		Luis Casas,				Laurel,	Mary1	and 2	0708			
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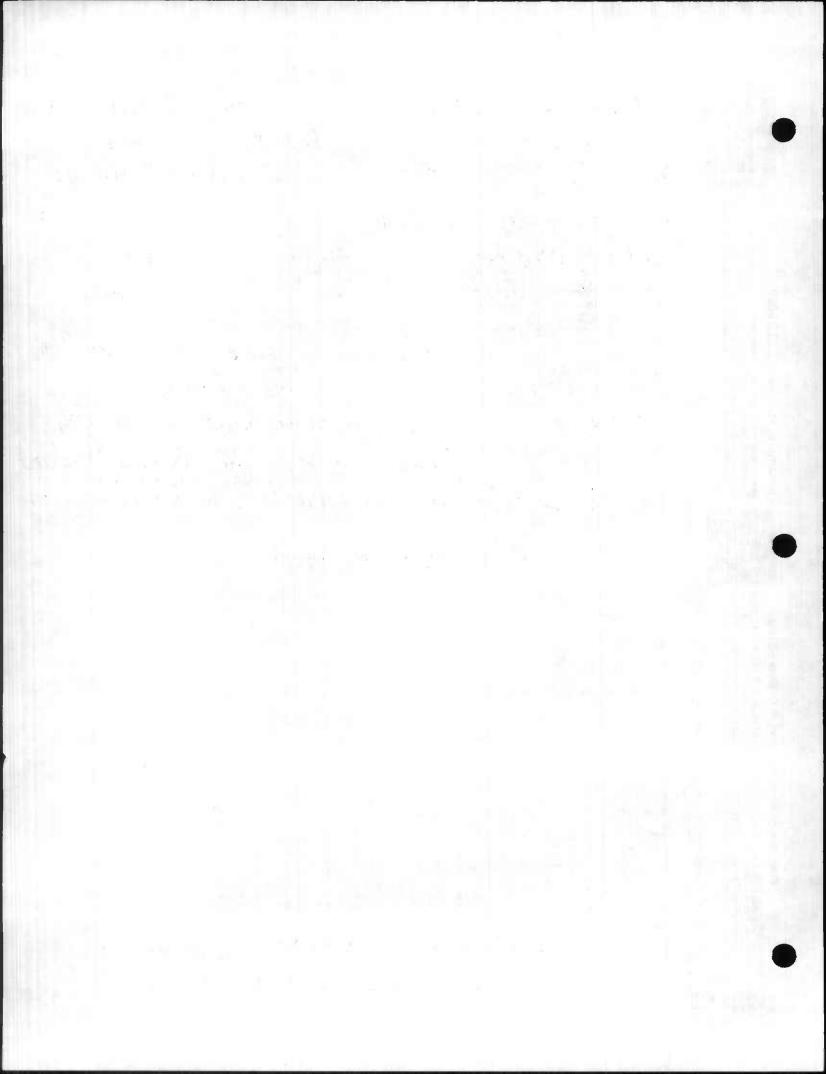
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	4 ☐ Donetion 5 ☐ Other (Speci	(fy) H	oly R	edeeme	r Cemete	ry 3/15	5/99	Balt:	more	Md.
by Physician/Medical Examiner	Immediate Cause (Final disassa or condition rasulting in daath) Sequentially list conditions, if any, leading to immediate cause. Enter Underflying Cause (Disassa or injury that Initiated avants resulting in death) Last	b. Due to	(or es e cor	nsequence of nsequence of the underlying	f):	int t.	1 🗆 Y	28 No	2 - 3	Approximate interval Between Onset and Deeth Onset and Deeth Onset and Deeth Onset and Deeth Onset and Deeth Onset and Deeth Onset and Deeth Onset and Deeth Onset and Deeth Onset and Deeth Onset and Deeth Onset and Deeth Onset O
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** March /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street end number) 4c. County of Death Examiner HMORE 8. Date of Birth 9. Birthplace (Stete or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) 5. Social Security Number **Funeral** 10 M 2□ F Months Days Hours Min. 214-10-435. Usual Residence of Decedant a Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiena.
ant: If Item 27 is marked other than "naturel", or items 23a or 28a-f show ury or other than the Mental Example oven, the Medical Example or notted at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Ma Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 W No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specity: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Coilege (1-4or 5+) LIVES DERVISOR 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) Be KOWEUX 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Maeyland WW 20b. Place of Disposition Name of cemetery, cremetory or other place 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Pages Depertment of Important: If it eny Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Edneral Service Licenses unoRal Part I. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryand Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Myocardia Infenction disease or condition resulting in death) Examine Examiner ettending physician and for use as the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequance of): signed by the e 23b. Did tobacco use copffibute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 20 No 3 Probably 4 Unknown à 24b. Were autopsy findings eveilable prior to completion of cause of deeth? should a Completed 24a. Was an autopsy performed? s cartificate has b 1 ☐ Yes 2 ☐ No 1 Yes 21/ No director, Hospital or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only the) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 1 ENaturel 5 Pending 1 ☐ Yes investigation 2 Accident 6 Could not be 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 4 \ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) end manner as steled. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. (Check only one) To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier D39297 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State MAR 1 6 1999

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death Day Vaa Month **Physician** Henrietta M. Carey 12, 1999 March 2:47pm /Medical 4b. City. Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** Sinai Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) **Funeral** Deys 1 M 2 F Yrs. 94 Director 214-74-6960 May 31 1904 Pennsylvania Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show idical Examiner must be notified at 1 ☐ Yes 2 No Mt. Washington Baltimore Directo MD 700.0 10g. Citizen of Whet Country? 10e Street end Number 10f. Zip Code USA 1812 Rambling Ridge Lane, Apt. 101 21209 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White à 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home n/a 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) should be Mental Henry Preuer Mary (unknown by informant) 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ž If Health Item 27 i Priscilla M. Carey/daughter 1812 Rambling Ridge Ln., Apt. 101, Mt. Wash., MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Melhod of Disposition Pages 1 Gurlel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 3/16/99 Druid Ridge Cem. Pikesville, MD 22. Name end Address of Fecility Lemmon Funeral Home Michael J. Flagle 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the diseese, or complications that caused the shock, or heart failure. List only one ceuse on each line. ations thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximete Interval Between Onsel and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Arthrosclerotic Cardiovascular Disease vears Examiner Due to (or as e consequenca of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) 80 attending p for use as 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II, Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 45 Unknown Breast Cancer Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed peen has l 1 Yes 2 X No 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ■ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No this funeral 27 Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After or Attending 1 Maturel 5 Pending 1 Yes 2 No death. Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direcompletely filled in b 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred et lihe time, date end piece, end due to the ceuse(s) end manner es steted. Medical Examiner: On the besis of examinetion end/or Investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. (Check one) 29b. Signatur 29c. License number 29d. Date signed (Month, Dey, Year) D0053495 March 15, 1999 SINAL HOSPITAL OF BACTIMO R Balto. 21215 30. Name end eddress of person who completed cause of death (Item 23e) (Typa, Print)

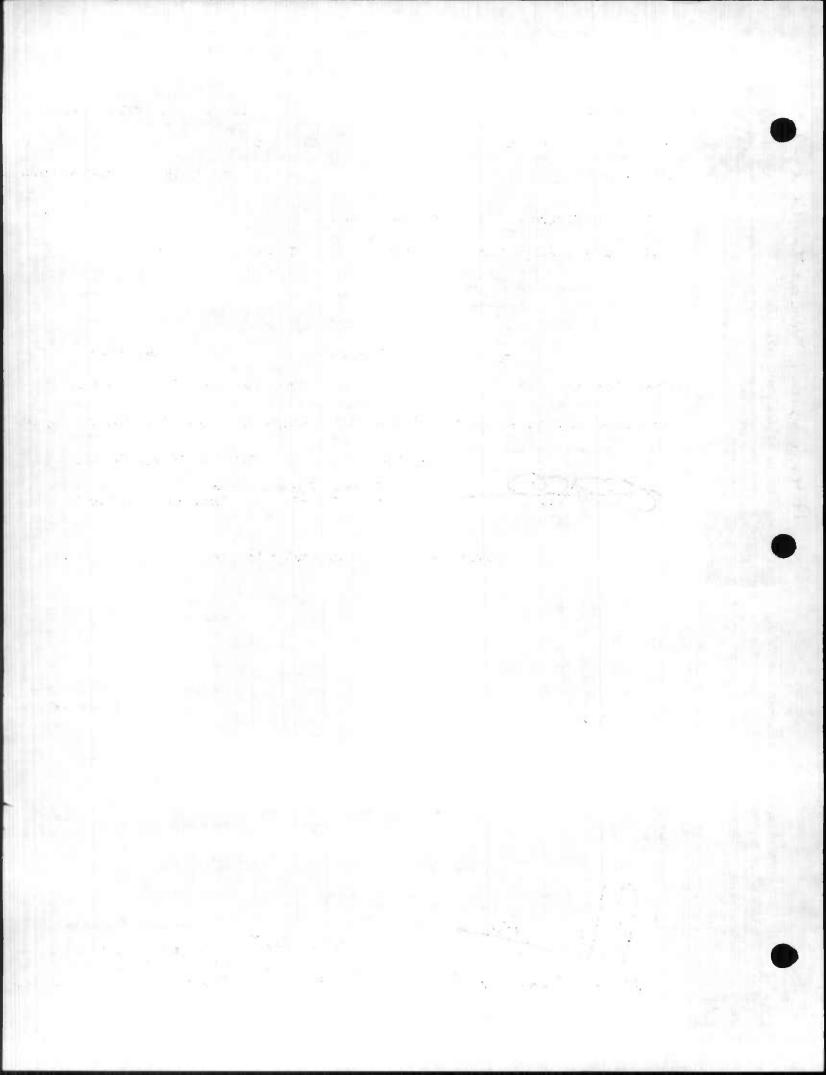
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32. Registrar's Signature

State Registrar

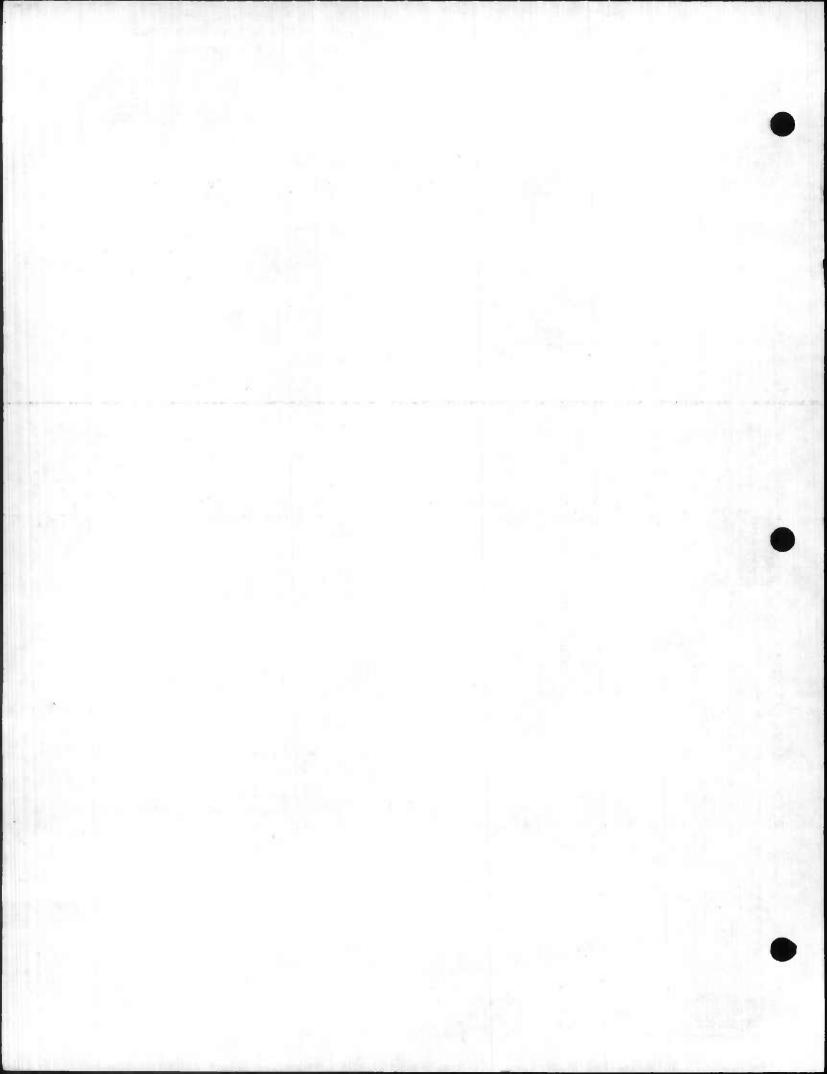
31. Date filed (Month, Day, Year)

A. Linewood as: Henriett



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Death Month Physician 11:00.P.M Annie V. Consp 999 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Street EllaMont Baltimore # Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 2 - 2 4 - 2 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral 10M 201 N.C. 71 212-30-7865 Director Usuet Residence of Decedent 10a, Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 1 Yes 2 No Director Md Baltimore must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23s or U.S.A 21229 Street Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

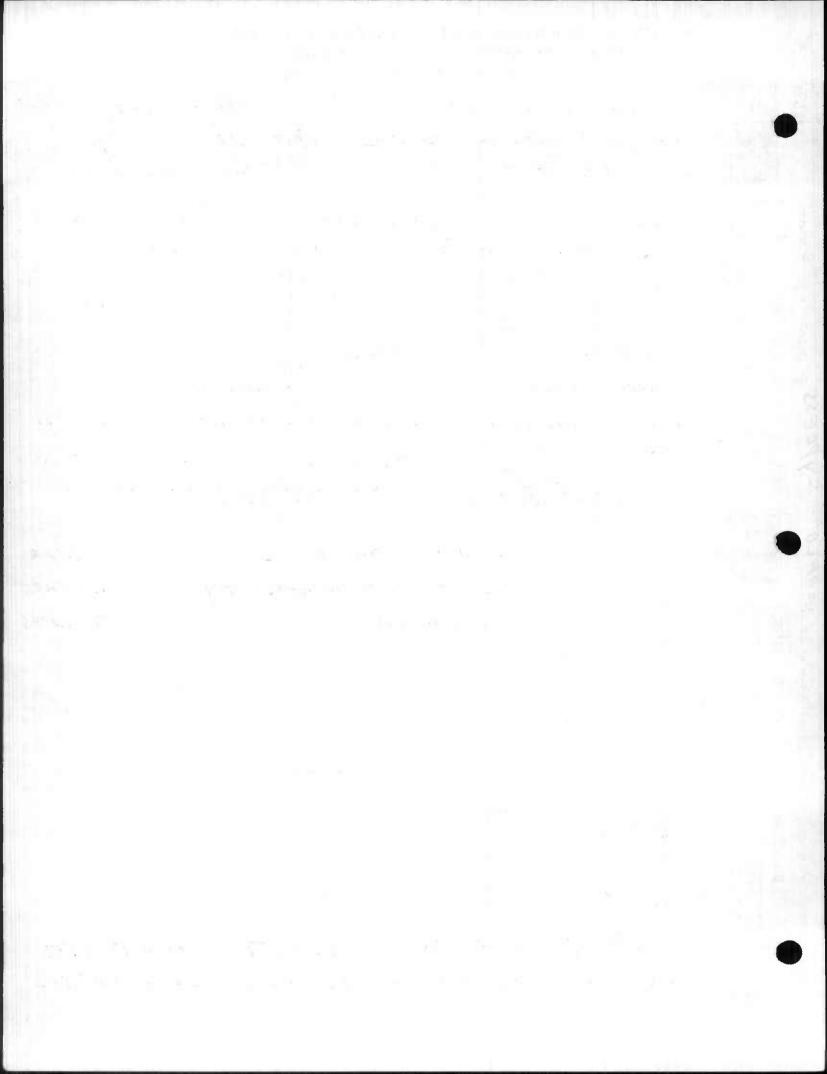
1 Yes, 2 No
If Yes, Give
Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stefus Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0020 Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be lited within Department of Health and Mental Hyguene Important: if them 27 is merited other than "n any Injury or other traumatic Various College (1-4or 5+) Elementary/Secondary (0-12) abover th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Kogers Wiler 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore, Md 21229 EllaMont Street Husband 9 N. 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Forest Owings Mills, Hd Vet 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee 22, Neme end Address of Fecility 4300 Wabach 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Hulnul Approximete Intervel Between Onset end Deeth **Physician** /Medical tmmediate Ceuse (Finel Pheumonia weeks diseese or condition resulting in deeth) Examiner Due to (or as e consequence of): Examine OF 18 month Adeno carcino ma lun physician and the bunel-transit certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es a consequence of) for use as 980 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vitai Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to Completed 24a. Wes an eutopsy performed? peen completion of cause of deeth? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physician: 25. Wes case referred to medical examiner?
1 Yes 2 No Be 26. Place of Deeth (Check only ope) 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 1 ☑ Netural 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? il Director: After ti ed in by the funera To the Hospital or within 24 hours after death.
To the Funeral Director: After manufactely filled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end ptece, end due to the cause(s) and menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 023809 3/15/99 M.Q 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greeve St., Baltimore, MD 21261 Cancer Greene boun Austra M.D. 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Bluer MAR 16 Registrar



	Certificate of Dea	ath	Reg. No.	
Div	Decedent's Nama (First, Middle, Last)	2. Date of	Death	3. Tima of Death
Physician /Modical	DONALD ROBERT CYPRESS	MAR	CH 13 V	999 4:35 A
/Medical Examiner		y, Town, or Location of D		
Examine	MARYLAND CENERAL HOSPITAL BY	ALTI MORE	C	171
Funeral	Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Undar 1 Yeer If Un	nder 24 Hrs. 8, Date of	Birth	9. Birtholace (Stata or Foraign
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to fee	MARYLAND N/A BALTIMORE CITY			Yas 2□No
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itam 27 is merked other than "natural", or items 23s or 28s-f si other traumatic event, the Medical Entanting mast be nothing To Be Completed by Funeral Director				e - Amarican Indien,
or items	Armed Forces? If Yes, specify Cuban, Max	xican, Puarto Rican, atc.	Bled	k, Whita, atc.
N A	3 Widowed 4 Divorced Yaar or Datas:	ecify:	Specify	BLACK
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r, the Medical I	15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work done during to	most of working	16b. Kind of Bu	usiness/Industry
를	Elementary/Secondery (0-12) College (1-4or 5+) lifa. DO NOT usa ratired)			
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any injury or other traumatic avent, the Monce. To Be Comp	Mildred Price/Mother 509 E. 43rd ST	T., Baltin	more Mar	yland 21212
5	a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, cramatory or other place)	Data	20c. Location -	City or Town, Stata
ŏ	Appurer 2 Defination 3 Definition State	к 3-18	ватитм	ORE, MARYLAN
2	4 Donetion 5 Other (Specify) KING MEMORIAL PARK 1. Signature of Funeral Service Licenses 22. Name and Addrass of Fa		DALITM	OKE, MAKILAN
DUCE.	WILLIAM C B	BROWN COM	MUNITY F	UNERAL HOME
	Mildre How 1206 W NORT			
-	26. Part1. Entar tha disaasa, or complications that causad the daeth. Do not antar the mode of dying, such shock, or haart failura. List only ona causa on aach lina.	h as cardiac or raspiretor	y errest,	Approximata Intervel Batween
ian				Onset end Death
cai	nmediate Causa (Final LUNG CANCER			IVEAR
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E	b. ACQUIRED IMMUNODE Dua to (or as a consequence of):	11101010	y	11 YETIK
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ledical Examiner	uusa. Enter Underlying ausa (Disaase or Inijury t initiated avants			1 MONTH
8	at initiated avants Dua to (or as e consequence of):			
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Physician				
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be detached for use by Physician/N				
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ica ica	3 Suicida 6 Could not be		n (Street and Numb	er or Rural Routa Number,
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Medical Certification:	Da. Cartifier (Check only (Ch	ta and place, and dua to , daath occurred et the tin	tha causa(s) and ma na, deta and place, a	nnar as stated. and due to the ceuse(s)
Med	and mannar stated.			
-	b. Signatura and title of certifiar 29c. Licensa numb	ber	29d. Data signed	d (Month, Day, Yaar)
	-Ghazala Htag/ MD P121	667	MARCH	13,1999
	Nama and address of parson who completed causa of death (Item 23e) (Type, Print)		12	11.1
	Chazala Afaq MD, GO MARV	ILAND G	ENEDRI	13,1999 HOSPITAL
State	Data filed (Month, Dey, Yaar) 32. Registrer's Signatura	-71100	MA THEN	11-01-17-11
State gistrar	MAR 1 6 1999			
J. L. I. al	MINIT D 1999			

Registrar DHMH 16 Rev 6/95

CYPRESS



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) CARMICHAEL **Physician** JOSE PH 4b. City, Town, or Location of Death 5:40 gm /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number, Examiner Baltimare Cit If Undar 24 Hrs. 8. Date of Bia STON LOCH RAVEN BLVD
Age (In yrs. lest birthday) If Under 1 Year GOOD SAMARITAN HOSPITAL 9. Birthplaca (State or Foreign Country) Caroling 7. Age (In yrs. last birthday) 5. Social Sacurity Number **Funeral** 342 44 6800 Usual Residence of Decedent Days Min 1 MM 2□ F **Director** with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Madical Examines must be notified at 1 Yes 2 No Maryland Director Dalti more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedant Evar in U.S.
Armed Forces?
1 \(\text{Yes} \) U.S. A 5200 21206 Funeral parms. Pages 1 and 2 should be filed within 72 hours after death to parment of Health and Mental Hyglena. 13. Was Decedent of Hispanic Origin? (Specify Yes or No It Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 M No Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation
(Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Hutomobile 1Rans portation 18. Mother's Name (First, Middle, Maiden Surneme) LAK 17. Fathar's Name (First, Middla, Last) Shedrard Carmichae 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Belationship (Type, Print) Avenue Dalfimon, Maryland 21213 3320 QUEEN Jay 20a. Method of Disposition ames 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrast,

| Approximate of the disease of the condition of th **Physician** /Medical Examiner Physician/Medical Examiner attanding physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence ot) USB as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? the 3₽Probably 4□Unknown signed by Chronic Rena 1 Yes 2 No þ 24b. Were autopsy tindings available prior to completion of causa ot death? Colitis 24a. Was an autopsy performed? Completed been s certificate has 2 No 1 ☐ Yes 2 ☐ HO or Attending Physician: 25. Was case reterred to medical examiner? 26. Piece of Death (Check only one) To Be Hospital: 1 Yes 202 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 1 DNaturel 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as stated. 29a. Certifier edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signatura and title of certities 29c. Licensa number 29d. Date signad (Month, Day, Year)

State

31. Date filed (Month, Day, Year) MAR 1 6 1999 Registra

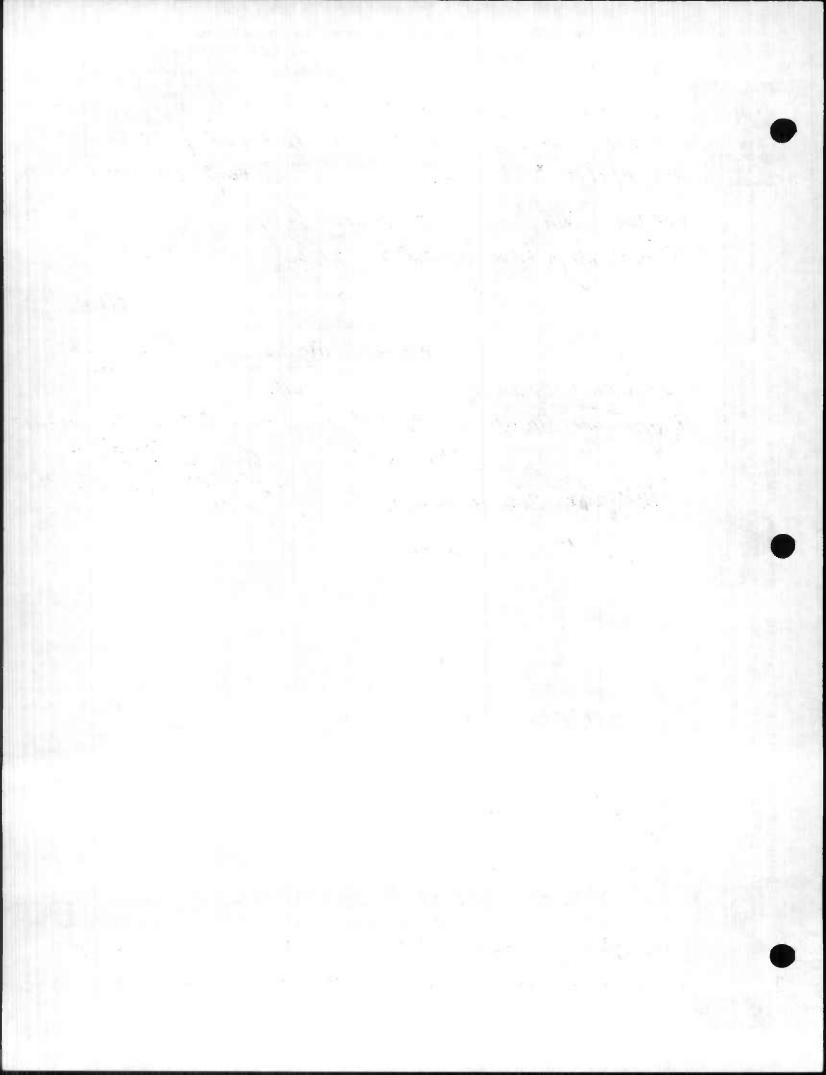
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FILMPONA

Good Samaritan

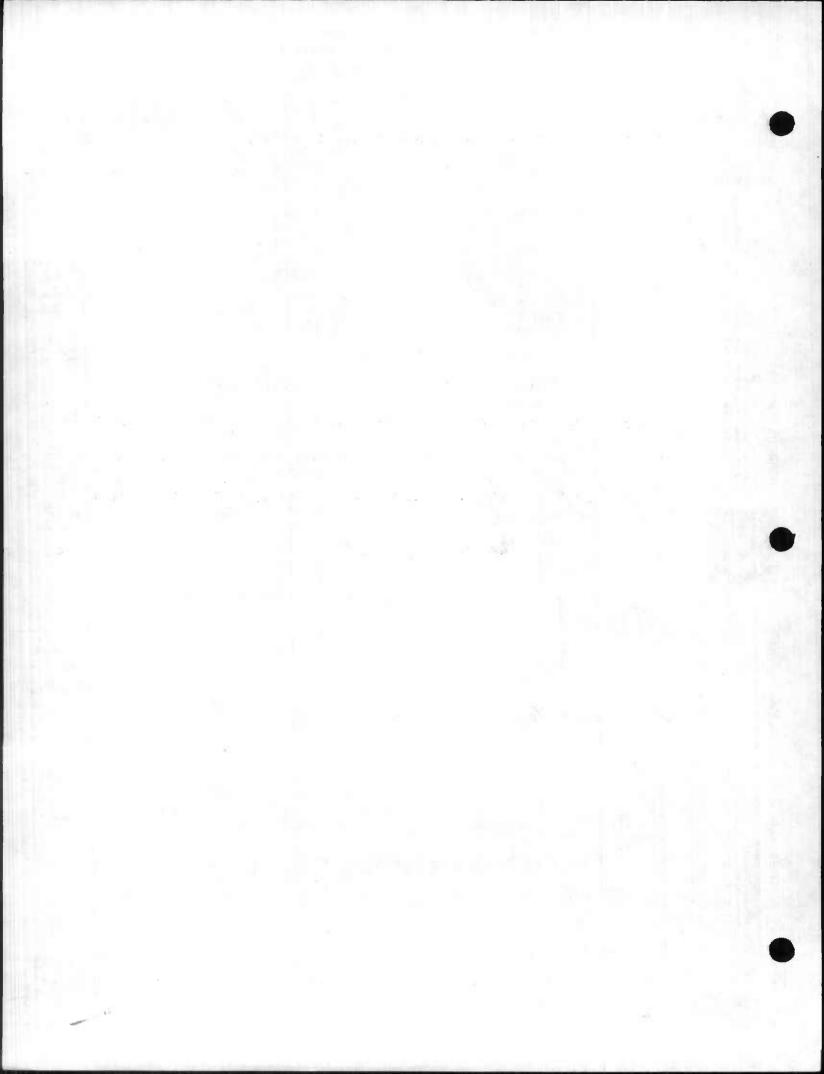
32. Registrar's Signature

hospital, 560/ LOCH RAVEN BLVD, BALTIMORE, MD 21239



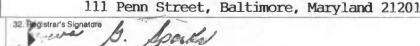
State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, L.)	est)	Cer	tificate of	Death	2. Date of De	Reg. No.	0.8 7.8 3. Time of Death
Physician	NORMA	Ε.	DEEM	ER		Month 03	Day	Year 999 11:18 AM
/Medical Examiner	4a Facility Nama (If not institution, git NORTH ARUNDEL HO	. 201	HOSPIT		4b. City, Town, or GLEN BURN		4c. County	
Funeral Director		Sex 7. Age (In yrs 1□ M 2\ F 78	last birthday) Yrs.	If Under 1 Year Months Days	If Undar 24 Hrs	8. Date of Bir	th v. Year)	9. Birthplace (State or Foreign Country) Maryland
Maryland of show fled.at	10a. State 10b. County MD ANNE AR		EN BURN					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
her death with the Marya items 23e or 28e-f shor cer.mast be notified at Tuneral Director	10e. Street and Number 127 STARLIGHT C	IRCLE		10f. Zip Code	2106	51	10g. Citizen of W	/hat Country?
Example Dy F	11. Marital Status 1 Naver Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Race Black Specify.	- Americen Indian, k, White, etc. White
ypiene. er than 'natur t, the Medical. Completed	15. Decedent's E (Specify only highest gr. Elementery/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give I	ant's Usual Occu kind of work done OO NOT use retire nation O	during most of wo ad)	orking	16b. Kind of Business/Industry Public Telephone	
a other event, the Be Co	10 17. Fathar's Name (First, Middle, Last		Intorn	lation o	*	me (First, Middle,		
marked marked marked av	Vincent Joseph 0'	Hare			Katie	Smith		
and N	19a. Informant's Name/Relationship	Type, Print)	19b. Meilin	g Address (Stree	t end Number or R	ural Route Numb	er, City or Town,	State, Zip Code)
of Health Itsem 27 Is r other tre	Lowell E. Deemer,					Glen Bu	rnie, Ma	ryland 21061
outment of He cortant: if ther Injury or oth	20a. Method of Disposition 1 Burial 2 Cramation 3 C 4 Donation 5 Other (Special Control of Control			sition (Name of patory or other pla ark Ceme		Date 3/15/99		city or Town, Stata
Depart Import any inj	21. Signature of Funeral Service Lice	· Shame		Name and Addr	ess of Facility ENS AVE.			HOME, INC. 21229
hysician	23a. Part 1/Enter the disease, or com shock or heart failure. List only				ing, such es cardia	c or respiratory a	rrest,	Approximete Interval Between Onset and Death
/Medical xaminer	Immediate Cause (Final disaase or condition resulting in deeth)	a. Pulsorary	or as a consequ					rentes
n end ist-transit Examiner	Sequentially list conditions,	b. Due to (or as a consequ	uence of):				
hysicia the bur dicai	Sequentially list conditions, if any, laading to immediate cause. Enler Undartying Cause (Disease or Injury that initiated avents resulting in deeth) Last	cDua to (or as a consequ	ienca of):		F. 11		
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s been s 2 should pieted							an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
ate he						10	Yes 2/1No	1 Yes 2 No
Be	25. Was case referred to medical examiner?					ath (Check only	one)	
00	1 Yes 2 No		ER/Outpatient	3LI DOA		Home 5 Resi		
1 5 E	27. Manner of Death 1 Alatural 2 Accident 3 Suicide 6 Could not be		28b. Time of Injury		Yes 2□No		how Injury occurr	
within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification	4 Homicide determined		iome, farm, stre	et, factory, office		City or To	on, Stete)	er or Rural Route Number,
n 24 hou he Fune pletely fii		ysician: To the best of my kno niner; On the basis of examina and mannar statad.						
o the	29b. Signatura and title of certifier	and the distance		29c. Licen	se nu <i>m</i> ber		29d. Date signed	(Month, Day, Year)
> = 0	Dela Alla	- Am		Da	4781		9/09	
	30. Name and address of person who	added to	m 23a) (Type, F	Print)	its are	Sint.	ر م س (an we m
State Registrar	31. Date filed (Month, Dey, Year) WAR 1 6 1999	82. Registrar's Sign	atur	loca V. 1	4 (1)	-		



State Registrar 30. Name a

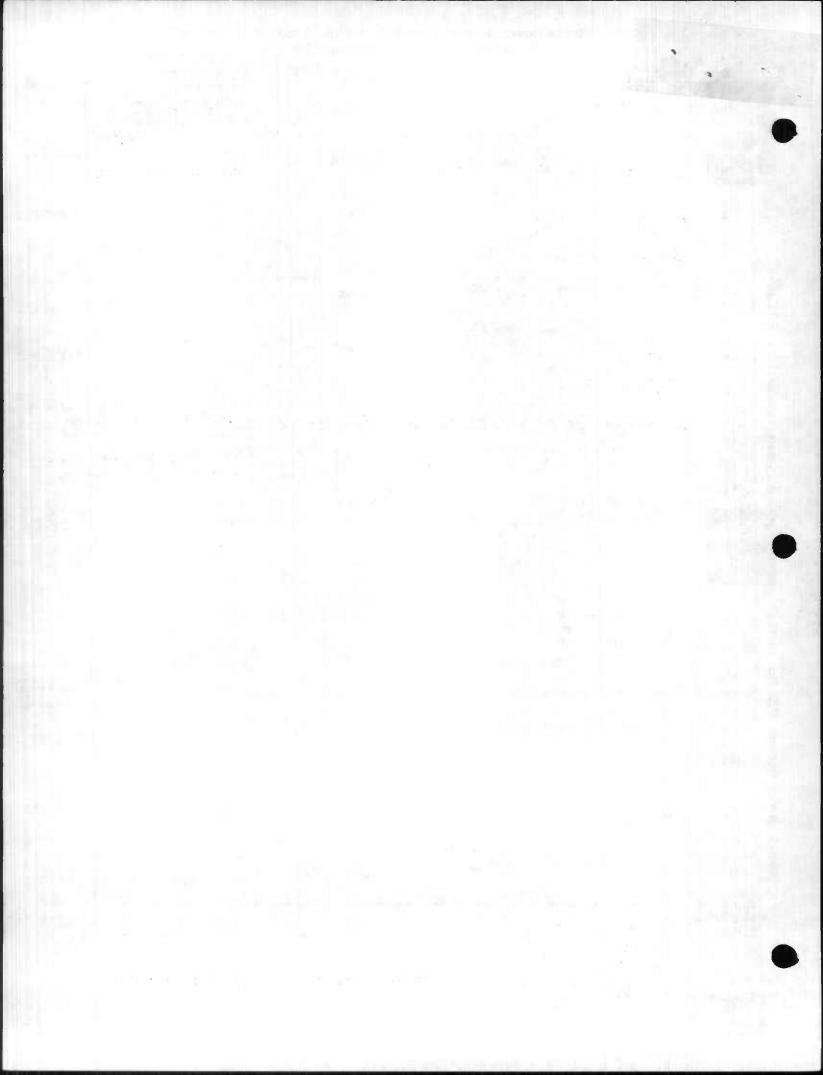
31. Date filed (MAR 16



awon who completed causa of daath (Itam 23a) (Type, Print)

O.C.M.E

MARCH 7, 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Peter Anthony DeLibro, Sr. March 1999 13, 2:25 AM /Medical 4a. Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpieca (Stata or Foreign Country) **Funeral** Days 1₩ M 2□ F Months Hours 102 38 6673 Yrs. April 15,1947 51 **Director** New York Usuei Residence of Decedent 10e Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County show 7 is merked other than "natural", or itema 23a or 28a-1 shor traumatic event, the Medical Examiner must be notified at Baltimore Maryland Baltimore 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 27 Eastford Ct. 21234 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Status 1 Never Married 2 Married 1 Yas 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest greda completed) permit. Pagas 1 and 2 should be filed within. Department of Health and Mentel Hygiene Important: If Itam 27 is marked other than any Injury or other traumatic avant College (1-4or 5+) Elementery/Secondery (0-12) Salesman Security / Retail 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Anthony DeLibro Edna Smith 19e. Informent's Neme/Raiationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Peter A. DeLibro, Jr. / Son 5211 Abbeywood Ct., Baltimore, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2XC remetion 3 ☐ Removel from Steta Green Mount Crematory 3/16/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications thet causad tha death. Do not enter tha moda of dying, such es cardiac or raspiretory errest, shock, or heart feilure. List only one cause on eech line. Intervel Batween Onsat and Deeth **Physician** /Medical Immediate Cause (Final e ESPHAGEAL CANCER diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner ettending physician and for use as the burial-transit Sequantielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initioled events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequenca of) Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown ð 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? Be Completed 24e. Wes en eutopsy page 2 has 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate director 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidance 8 MOther (Specify) HOSPICE 70 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA his To the Hospital or Attending Phy within 24 hours aftar deeth.

To the Funeral Director: After this completaly filled in by the funeral is 27. Manner of Death 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Medicai 11X Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 | Medical Examiner: On the basis of exeminetion end/or Investigetion, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. 29e. Certifier (Check only one) 29b. Signature 29c. License number 29d. Dete signed (Month, Dey, Year) 15.88 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

MAR 1 6 1999

31. Dete filed (Month, Day, Year)

32 Registrer's Signetura

the Meryland

21215-0020

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Lokamann F
Baltimore, Maryland 2

certificate be executed

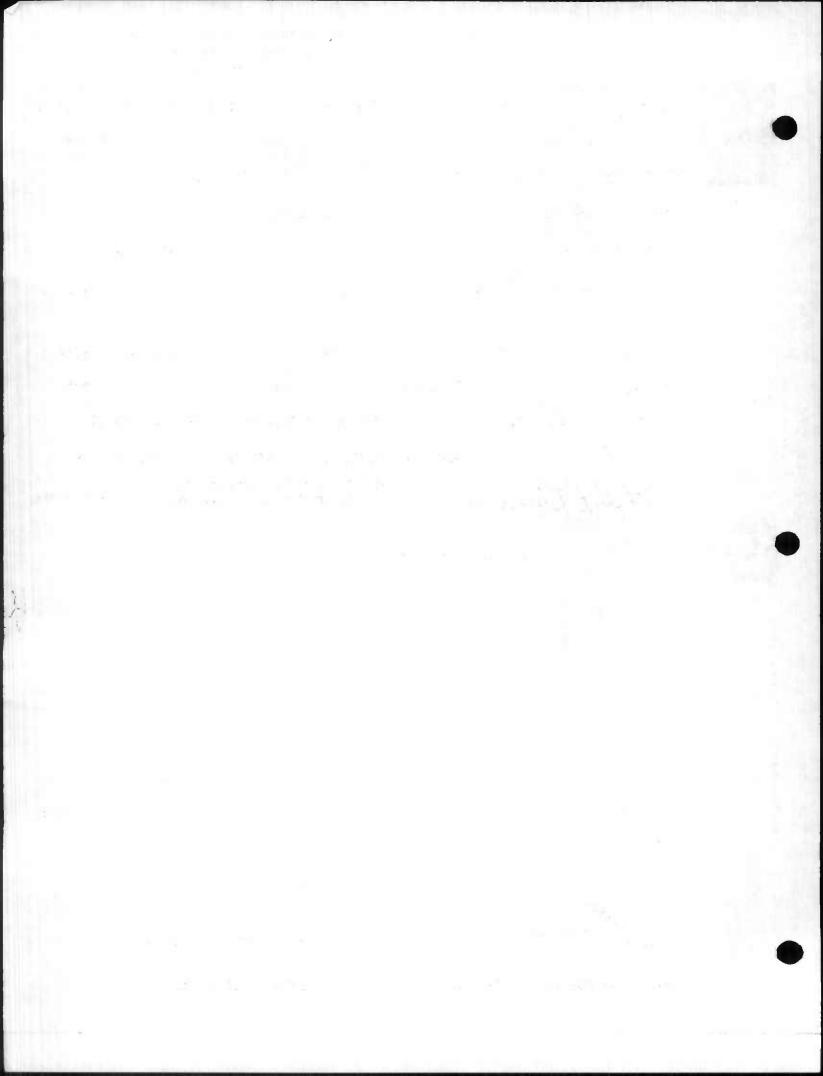
Box 68760.

P.O.

Records,

of Vital

Division



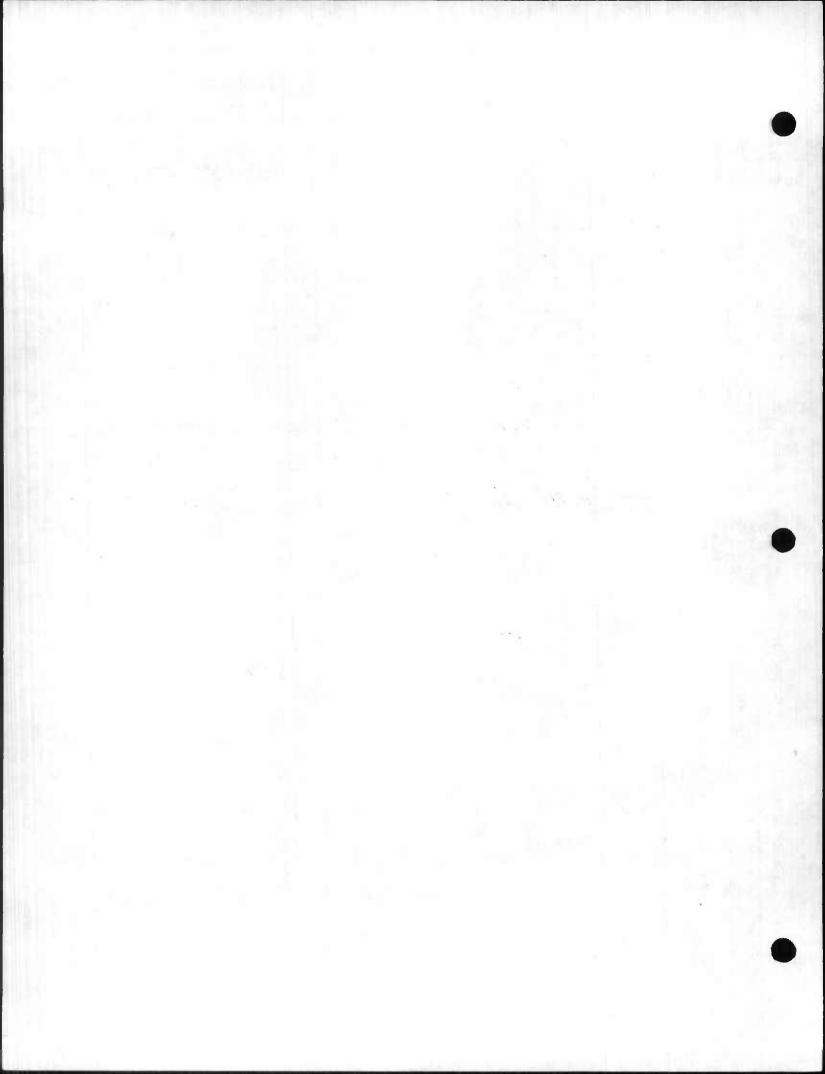
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** Irene Ellsworth Beatrice March 12, 1999 6:15 a.m /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Hamilton Eldercare Genesis N/A Baltimore If Under 1 Yee If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys 1□ M 20 F Hours Director 523-16-7765 94 30, 1905 Minnesota Usual Residence of Decedent with the Maryland 10a. Stete 10b. County show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Directo Maryland Baltimore Overlea 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 arriner must be 5302 Kenwood Avenue 21206 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Detes: 14. Race - Amarican Indien, 11 Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, atc. pernit. Pages 1 and 2 ahould be filled within 72 hours after. Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural", or the any Injury or other traumatic event. the Medical Exemple. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 th. Grade College (1-4or 5+) Teacher Education 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Be Terhell Olive Henry Westbrook 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5649 Whitby Road Baltimore MD Glennys R. Wise / Daughter 21206 20e. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cem. 3/14/99 Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John C. Miller, Inc. 6415 Belair Road Baltimore 21206 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, . List only one cause on each line. 23a. Pert . Enter the diseas shock, or heart tellure. Approximata Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) Examiner Examiner ician and burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of). physician a Box 68760. Physician/Medicai Due to (or es e consequence of): for use P.O. signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 20 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Division of Vitai funeral director. Be 25. Wes casa referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 1 Naturel 5 Pending investigation 1 TYes 2 TNo 24 hours after death. Funeral Director: A 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide Hospital 11 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifian completely (Check only one) To the Vithin 2 29b. Signeture and little of certific 29c. License numbe 29d. Dete signed (Month, Day, Year) 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) MD 21237 M.D. 17 Fontana Lane Baltimore Mohammed Rahnama 31. Dete tiled (Month, Day, Year) 32. Registrar's Signetura

DHMH 16 Ray 6/95

State Registrar

MAR 1 6 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mance 6:15 PM 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Prince Regional George's Laurel Hospital Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) 5. Sociel Security Number Birthplece (State or Foreign Country) Months 1 M 2 F 70 Yrs. 9, \$ept. 1928 Arkansas 429-46-7376 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3396 Wye Mills South 20724 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No if Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: White 30XWidowed 4 □ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Otto Luper Mary A. Wallis 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) M. Angie Faulkner/Daughter 3396 Wye Mills South, Laurel, Maryland 20724 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cem. 3/17/99 | Arlington, Virginia 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es e consequi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 100 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one)

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Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hyglens. In the Manyland Phyglens with: If farm 27 is marked other than "naturel", or items 23a or 28a-f ahow my or other traumatic event, he legical Examples must be notified at my or other traumatic event, he legical Examples.

Baltimore, Maryland 21215-0020

physician end the burial-transit attending p for use as signed by the a certificate has b lirector, page 2 s

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760, Attanding Physician: After this funeral Hospital or Attand 24 hours after death Funeral Director:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Monpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Day Year) 27. Manney of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 Tes 2 No

investigation 2 Accident 3 Suicide 6 Could not be determined 4 Homicide

28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

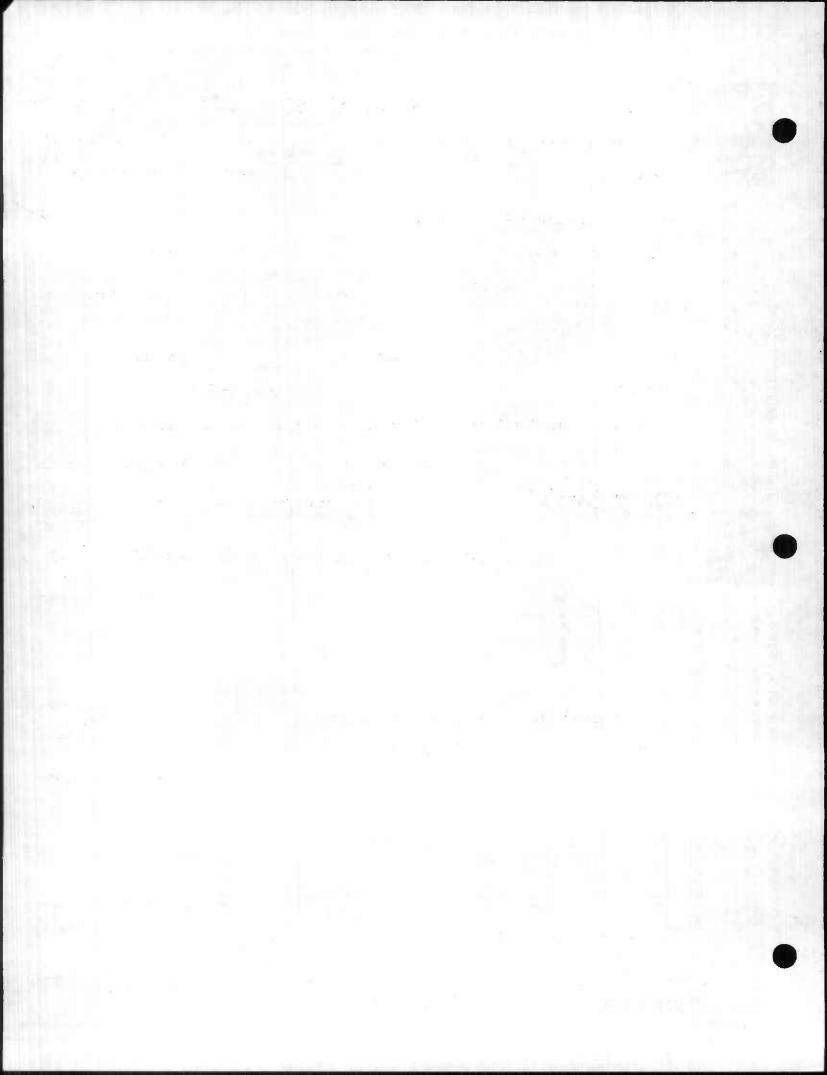
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29b. Signeture end title of ca 29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daeth 3. Time of Death Month 344 HELEN FRAZIER MARCH 1999 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death NIA LIBERTY MEDICAL (ENTER BALTIMORE If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) 1 M 2 F Months Days Hours Yrs. 215.12.3525 MO Usual Rasidance of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2503 VIOLET USA 21215 AVENUE 12. Was Decadant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indien, Black, Whita, atc. 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Never Married 2 Married 1 Yas 2 No Specify: BLACK 3 Widowed 4 □ Divorced 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) SERVICE 9 TH MIANAGER GRADE 1000 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) KEYNOLDS MARY TITZHUGES KICHARD 19a. Informant's Nama/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) DRIVE. BALTO. MD. 3112 GELSTON JEAN TRAZIER 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata KING MEMORIAL YARK 3-16-99 4 ☐ Donation 5 ☐ Othar (Specify) KANDAUSTOWN, 21. Signatura of Funeral Sarvice Licensee 22. Nama and Addrass of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the chaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or has cardiac or respiratory arrest, Approximata Intarvai Between Onset end Death immediate Ceuse (Final MYDLARDIAL INFARCTION 2 DAYS disaasa or condition rasulting in daath) MEART ASEASE ARTERIOSCZEROTIC UNICNUWN Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of): Dua to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tyes 2 No 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? - HYPERTENTION complation of causa of death? DIABETES MEZZITUS 1 Yas 2 No 1 Yas 2 No

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Baltimore, Maryland 21215-0020

- CARDI'DMY OPATHY

25	Was casa rafarrad to medical axaminar? 1 ☐ Yas 2 No		26. Piace of Death (Check only ona)							
			Hospital: 1 Inpatient 2	2 ER/Outpatient		DOA Othar:	□ Nursing	Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)		
27	2 Accidant	5 Panding Invastigation		28b. Tima of Injury	М	28c. Injury et Work?	2 🗆 No	28d. Dascribe how Injury occurred		
	3 ☐ Suicida 4 ☐ Homlcida	6 Could not be dataminad	28a. Place of Injury - Albuilding, atc. (Spe	homa, farm, stree	t, fact	ory, office		28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)		

3 Suicida dataminad 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homlcida

12 Certifying Phyalclan: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifiar (Check only one) 29b. Signetura end titla of certifiar

MD.

29c. Licansa number 29d. Data signed (Month, Day, Year)

30. Name end address of person who complated cause of death (Itam 23a) (Type, Print)

23300 diberty Medical Centr

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State Registrar 31. Data filad (Month, Day, Yaar) MAR 1 6 1999



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: #5 PER F.H. G770 4-8-99 WR. 1. Decedant's Nama (First, Middla, Last) 2. Dete of Daath Month Milo Lynn Ford
4a. Facility Nama (If not institution, giva street and number) 12, 1999 March 8:30 AM 4b. City, Town, or Location of Deeth 4c. County of Death 5114 Woolverton Ave. Baltimore Hours Min. 8. Date of Birth NOV. (Month Day Year) Dec. 23,1956 5. Social Sacurity Number 4.NK 6. Sax If Under 1 Year 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign 1□ M XXF Baltimore 43 Yrs 214-64-1172 Usual Rasidanca of Dacadent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 yes 2□No Maryland Baltimore Baltimore 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 5114 Woolverton 21215 U.S.A. 12. Was Dacedent Evar in U,S. Armed Forces? 14. Raca - American Indien, Bleck, Whita, atc. 11. Merital Status Was Dacadent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 Naver Merried 2 Marriad 1 ☐ Yes 2 ☐ No If Yas, Giva XX Yaar or Datas: Specify: Black 1 ☐ Yas XX No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) Nurese Assistant Hospital 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Leon Ford Margaret Hope 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat and Number or Rurel Route Number, City or Town, State, Zip Code) Arthur B. Workman 5114 Woolveton Ave. Baltimore, MD 21215 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, Stata XXBurial 2 Cramation 3 Ramoval from Stata Loudon Park Cemetery 3/16/99 Baltimore, MD 4 ☐ Donation S ☐ Othar (Specify) 22. Nama and Addrass of Facility Loudon Park Funeral Home Nurs of Fundral Service L 3620 Wilkens Ave. Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intarval Batween Onsat and Death Immediata Causa (Final Hypoglycemia disaasa or condition resulting in death) Type 1 Diabetes Saquantially list conditions, if any, leeding to Immadiata cause. Enter Undarlying Cause (Disaase or injury that initiated evants rasulting In daath) Last Due to (or as a consaguance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown HIV 24b. Wara autopsy findings available prior to complation of causa of death? 24e. Wes an eutopsy performed? Poor diabeter Control related to above 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminar?
1 Yas 2 □ No 26. Place of Deeth (Check only ona) Hospital:

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any Injury or other traumatic event

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Completed

other traumatic event, the Medical Examiner must be notified at

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72 hours efter

filed within 7 Hygiene.

Baltimore, Maryland 21215-0020

Completed by Physician/Medical Examiner Be Medical Certification: To

physician and the buriel-transit signed b peed hes After this To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: Affe completely filled in by the fune.

The law requires that the death certificete be executed

Box 68760.

Records, P.O.

Division of Vital or Attending Physician: 27. Mennar of Death

State Registrar

28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 1 Natural 2 Accident 5 Panding invastigation 1 ☐ Yes 2 ☐ No 6 Could not ba dataminad 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) 4 - Homicide 29a. Certifier (Check only one) 1x Certifying Physicien: To tha best of my knowledga, daath occurred at tha tima, data and placa, and due to the cause(s) and mennar as steted.

2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the ceuse(s) and manner stated. 29c. Licansa number 29d. Date signed (Month, Day, Yaar)

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Othar: 4 Nursing Homa 5 Rasidance 6 □Othar (Specify)

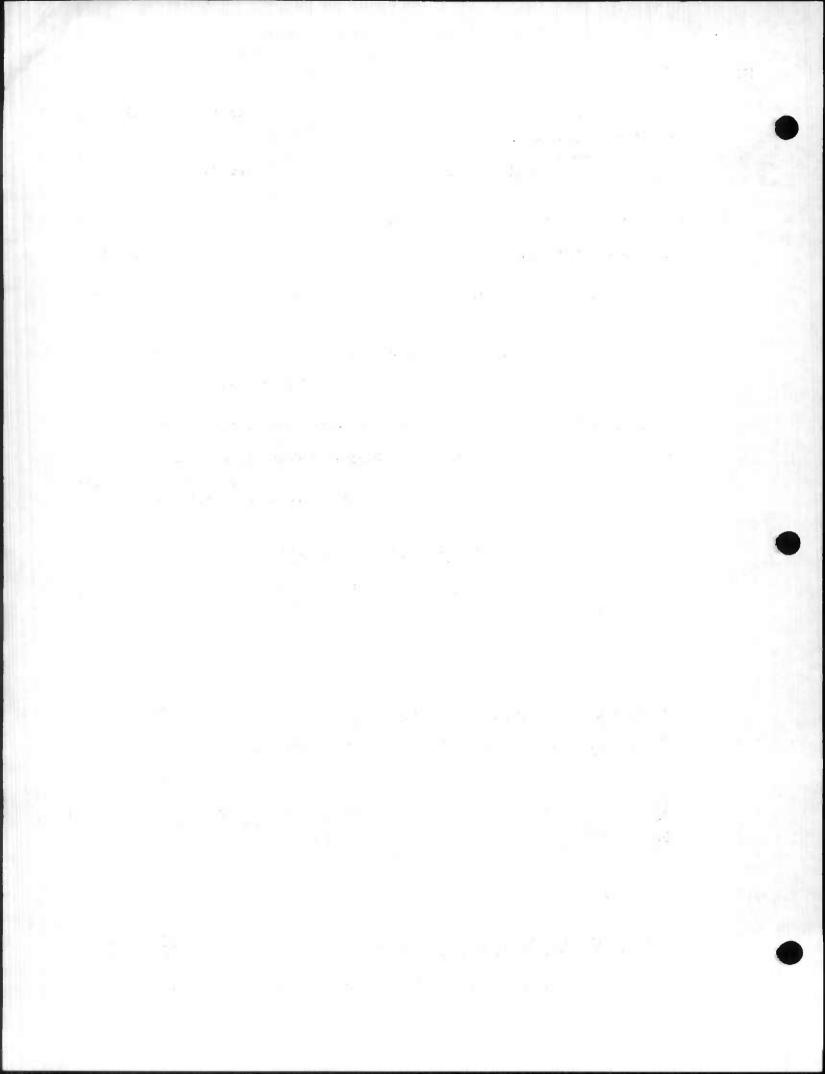
28d. Dascribe how Injury occurred

30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print)

W. ROBERT 5, LANGE Evtawst 16 31. Data filad (Month, Day, Yaar)

MAR 1 6 1999

33 Registrar's Signeture



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Fentuck 1428 March 10 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth SINAI HOSPITAL BALTIMORE If Under 24 Hrs. 8. If Under 1 Yeer 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Min Months Deys Hours 1□ M 2□ F 91 Yrs. 216-01-5809 MARYLAND OCT. 30, 1907 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD N/A 1√ Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 6965 GLENHEIGHTS ROAD 21215 U.S.A. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 □ Widowed 4 □ Divorced WHITE 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 10 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) KALMAN FEINSTEIN REVA (UNKNOWN) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KARL FEINTUCH / SON 2851 COUNTRY LANE, ELLICOTT CITY, MD 21042 20a. Method of Disposition 1 IABurial 2 □Cremation 3 □Removal from State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete S ☐ Other (Specify) 3/11/99 ROSEDALE, MD 4 Donation ANSHE NEISEN CEMETERY 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 21. Signature Tuneral Service Lig 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Iter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in death) - A CUTE MYO CARDIÁC INFARCTIÓN Due to (or es e consequence of): GENGRALIZED ARTEMOSCICHOSIS 10 4 CARC Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown HYPERTENSION - DEM GNEIA 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en autopsy REFUSAL TO CAT- TUBE FEBREN 1 ☐ Yes 2 ☐No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Physician

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r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

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Baltimore, Maryland 21215-0020

Examiner Physician/Medical

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Medical

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 25. Wes case referred to medical exeminer? Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner stated. 29e. Certifier

29c. License number 29b. Signeture end title of cartifier M.D

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29d. Dete signed (Month, Day, Year) MARCH 10-1999

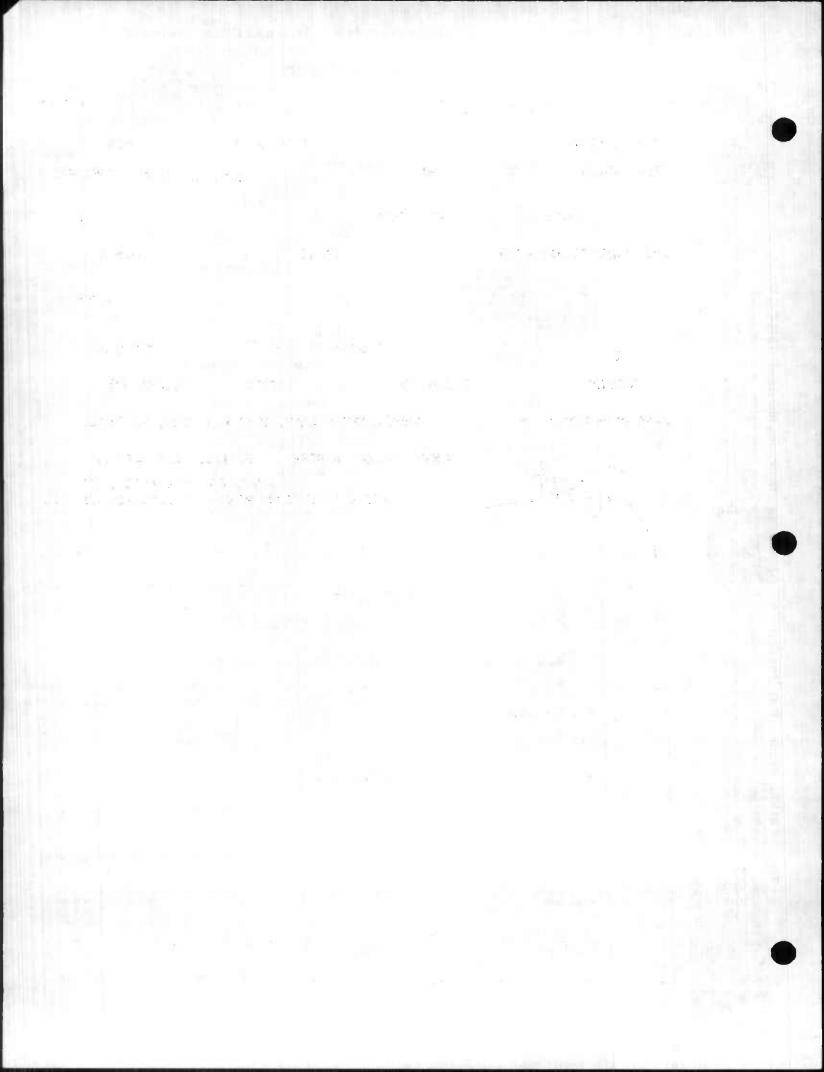
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7445 FURMICE BRANCH Rd GLENBURNIE Md 21060 REIDER M.D. RUBEN

31. Date filed (Month, Dey, Year)

32. Registrar's Signeture

24 hours e



Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth Month **Physician** dwards :25 PM 6000 Man 1999 MARCH 10 /Medical 4c. County of Death 4a Facility/Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FRANKlin Square 5. Social Security Number 6. Sax Rosedale Hospilal Cen 1. Aga (In yrs. last birthday) TIMORE If Under 24 Hrs. 8. Date of Birth 9. Birthplaca (State or Foreign Country) **Funeral** Months Days 1 M 2 F 214-01-0952 Usual Residence of Decedent Director the Marylend 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location notified at 1 ☐ Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? me 23a or 5 13. Was Decedent of Hispanic Origin? (Specify Yas or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) by Funeral ortant: if item 27 is marked other than "natursi", or items injury or other traumatic event, the Medical Examiner ms 12. Was Dacedant Evar in U,S. Armed Forces? 1 Syes 2 □ No 14. Race - American Indian. 11. Marital Status Biack, Whita, etc Pages 1 and 2 should be filled within 72 hours effer on ant of Health and Mental Hyglene. Int: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married Specify: White 1 Yes 2 No Yes. Give Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Telephone Elementery/Secondery (0-12) College (1-4or 5+) SUPERVISOR 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROYAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IIMONIUM. Md 21093 March 11 20a. Method of Disposition 20b. Piace of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burlal 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Evans Funeral 23á Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failura. List only one cause on each line. Baltimore **Physician** /Medical Immediate Cause (Finai Preumonia disaase or condition resulting in death) 10 DAYS Examiner Due to (or as a consequence of) Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): 98 950 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown PROSTATE 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificate or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Naturai 5 Pending investigation efter deeth. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 4 Homicide

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene)

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State Registrar

Medicai

31. Date filed (Month, Day, Year) MAR 1 6 1999

29a. Certifies

(Check only one)

29b. Signature and title of certifier

Michael

32. Registrar's Signature

9000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Picco

FRANKlin Square DR. BAITIMORE, MARYLAND 21237

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated.

29c. License number

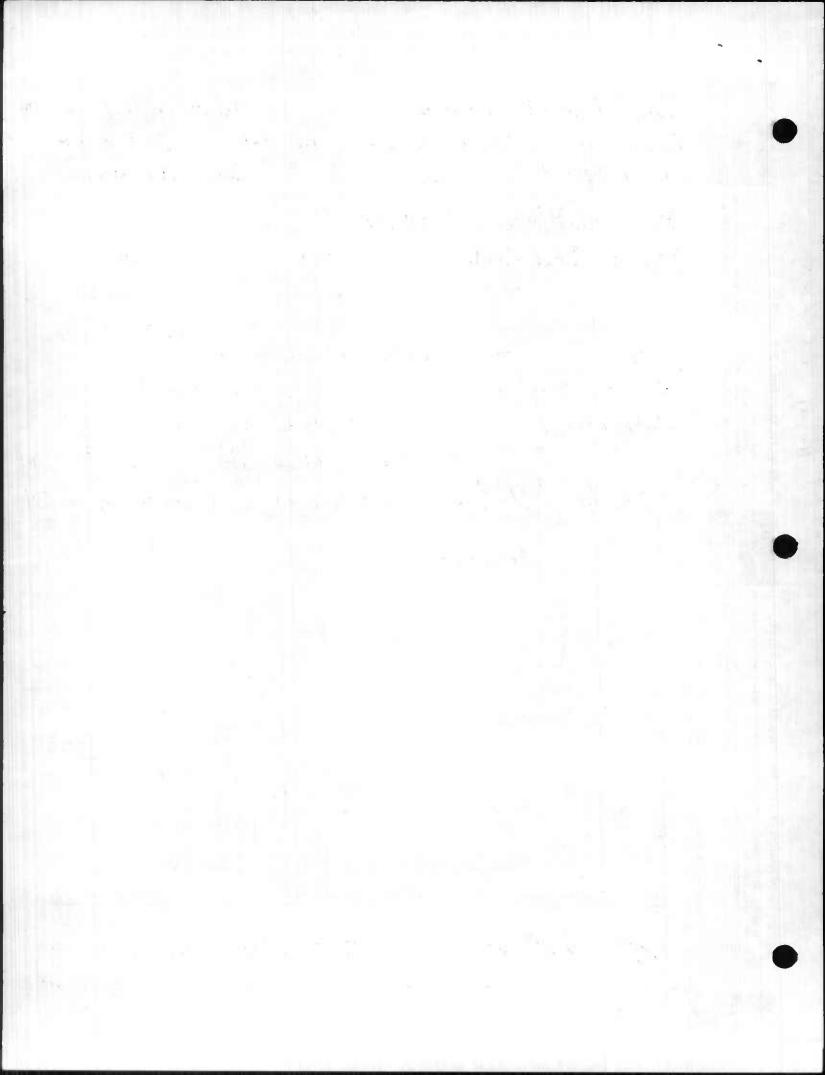
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29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

24 hours e Funeral C Hospital

within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** Charlotte Smith Gussow 03 11 1999 9:25 am /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Broadmead Cockeysville **Baltimore** If Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number Birthpiaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2□F Yrs 114-03-8275 87 Director June 15 1911 Massachusetts Usual Residence of Deceden deeth with the Marviend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Medical Examiner must be nutitled at Director 1 Yes 2 (No Cockeysville Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21030 USA 13801 York Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Maritai Status pernit. Pages 1 and 2 should be filed within 72 hours efter or Department of Hatilth and Mental Hygiena. Important: If item 27 is marked other than "naturel", or iter any injury or other treumatic event, the Medical Expansion 1 ☐ Yas 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yas 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Art Restoration Conservators 04 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumema) Be George Lawrence Smith Charlotte Eliot 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Routa Number, City or Town, State, Zip Code) R.R. 2, Box 105, Randolph, VT 05060 Priscilla T. Spahn/Daughter 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 3/12/99 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Baltimore Washington Crematory 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 21. Signature of Funeral Service Licenstee 22. Nama and Address of Fecility
Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Entar the creasa, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intarvai Between Onset and Death **Physician** /Medicai Immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): nding physician and use as the bunal-transit Sequentielly list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury Ihal Initiated events resulting in death) Last Due to (or es a consequerice of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): ed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitai: 1 inpatient 2 ER/Outpatient 3 DOA 1☐ Yes 2☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this tha funaral 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 PNaturel death. To the Hospital or Attendiwithin 24 hours after death.
To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stata) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and manner stated. edical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person 23af (Type, Print)

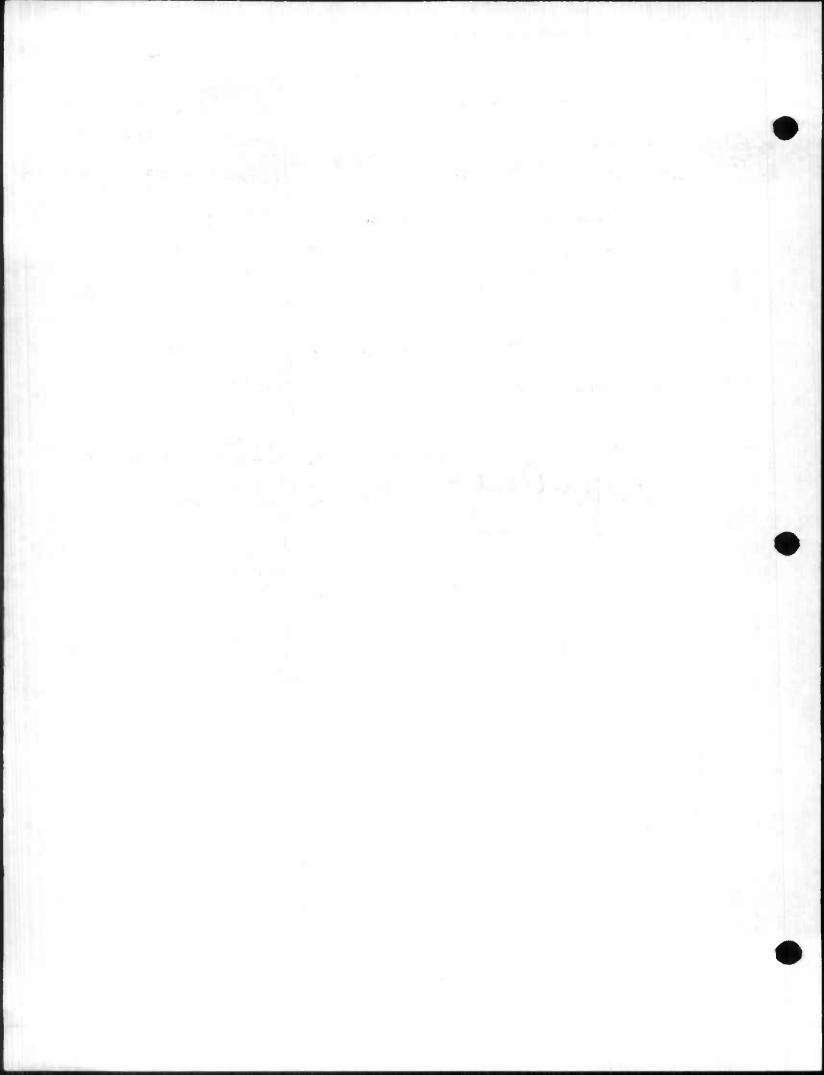
Registrar

State

31. Date filed (Month, Day, Yaar)

MAR 1 6 1999

32. Registrar's Signature



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Death Month 9:26 AM Morris Garbis March 12 1999 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Hospital of Baltimore Sinai Baltimore n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 6. Sex XM 2□ F Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Months Days 213 09 4782 Yrs. 83 Aug. 8 1915 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits Maryland **Baltimore** Baltimore 1 Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1825 Rambling Ridge Lane 21209 #301 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker Real Estate 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Botwinik Garbis Israel Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ruth Garbis / Wife 1825 Rambling Ridge Ln., #301, Baltimore, MD 21209 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Green Mount Crematory 3/15/99 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21286 Approximete intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intra peritonee Bleed Attack Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2000

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

à

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Pyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical France.

physician end the buriel-transit signed by the e should I certificate has b lirector, pege 2 s

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The law requires that the death certificate be executed ettending phythis funeral After death. ofter death.
Director: A

Division of Vital Records, P.O. Box 68760.

Physician/Medical Examiner Completed Be To

Hospital or Attending Physician: Certification: 124 hours efter on Funeral Directions of Funeral Directions of Funeral Piliped in bright of Funeral Piliped in Bright of Funeral Pil edical Willin 2

State Registrar

29b. Signature and title of certifier

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 \(\text{Homicide} \) Medical Examiner: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one)

> 29c. License number 29d. Date signed (Month, Dev. Year)

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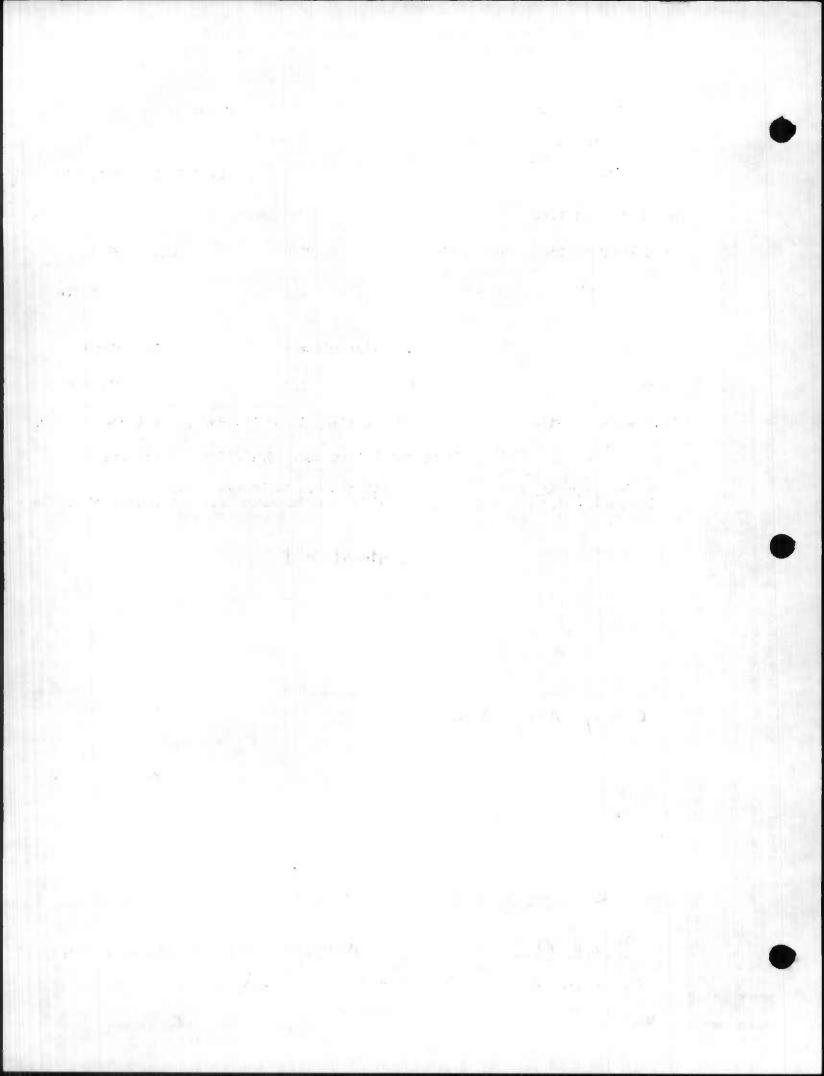
March 12 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Christopher 1401 Davis

West Belvedere Avenue

32. Registrar's Signature 31. Date filed (Month, Day, Year) 1999 6



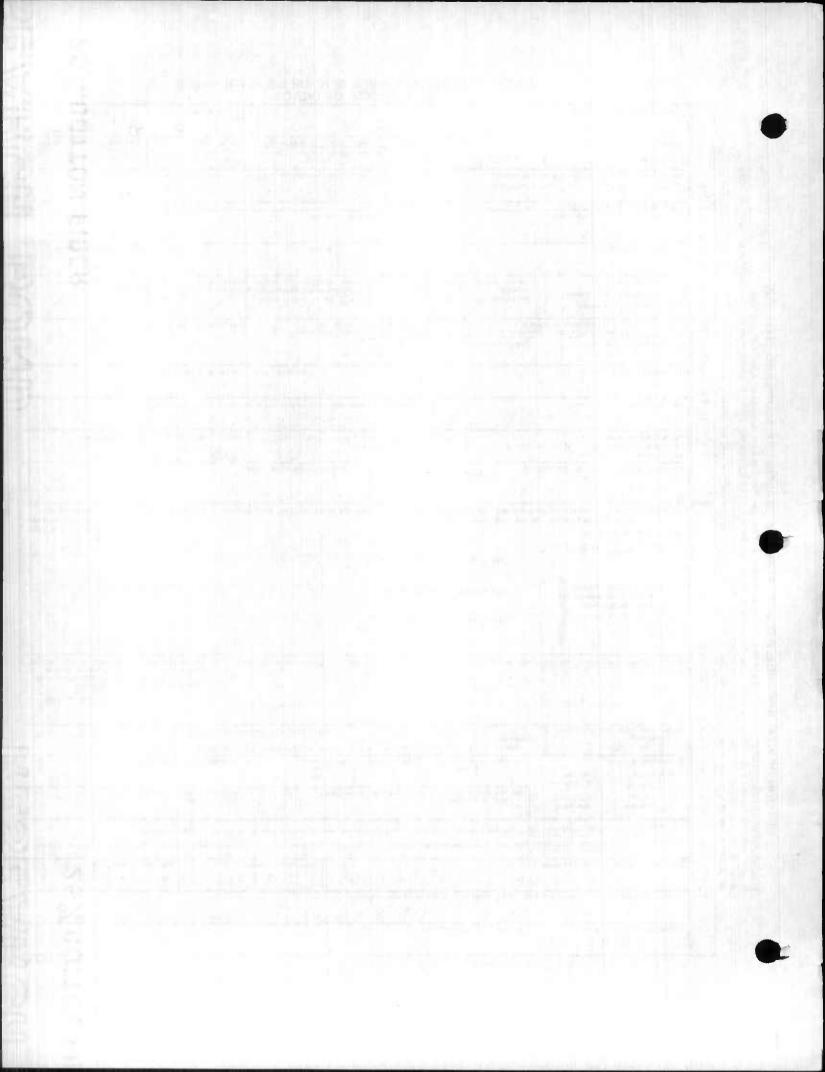
DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

MONTH DAY YEAR										3. TIME OF DEATH							
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. let					t birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH 8. BIRTHPL/			IPLACE (State or Fore					
094-30-0608			1 □ M 2 🖾 F	84	YRS.	MONTHS	DAYS	HOURS	MIN.	FEB.		1915	15 NEW YORI				
99. FACILITY NAME (If not institution, give street and number) NORTH OAKS HEALTH CENTER						9b. CITY	b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF E						EATH				
			Κ		BALTIMORE BALTIMORE						10RE						
10e. STATE 10b. COL			JNTY			r, TOWN C							10d, INSIDE CITY				
	MD	BA	LTIMORE		В	BALTI	MOR.	E						LIMITS?			
10e. STI	REET AND NUN						10	f. ZIP COD				10g. CIT		WHAT COUNTRY?			
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Elementary/Secondary (0-12)		College (1-4 or 5	- Ha	Do NOT us	e retired.) SMAKE		ost or working			OWI	N HON	ME					
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100 1011	ORMANT'S NA					ADDRESS	/Da : 1		BERT		00		NKNOV	WN)			
			ENICK / S							DR . ,				72			
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20a. METHOD OF DISPOSITION 1 © Burlel 2 Cremation 3 M Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of competery, crematory or other place) NEW MONTEFIORE CEMETERY 3-1/-99											NELA						
21. SIGR	ATURE OF THE	NERAL SERVICE	LICENSEE		01111111			ND ADORE		CILITY							
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year Physician 45 Am Gyand Zhuntse 13th Kimma 1999 march /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death alto, If Under 24 Arc. Ma Balto. City W. Belefflue re X7. Age (In yrs. last birthday) 2434 If Under 9 Birthplaca (State or Foreign Country) **Funeral** Days Hours 1 M 2 W Yrs. ussia Director 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hams 23a or 28a-f ahow the Medical Examiner must be notified at Balto 18 Vas 2 No Director 10f. Zip Code 10g. Citizen of What Country? 2120 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indien Bleck, White, etc. 11. Marital Status e filed within 72 hours after d al Hygiena. other than "natural", or Item 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic eventables. 8 Nerses Gyandzhuntsev Anaida Auanesova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Ironwood Circle, Baltimore, Md. 21209 Gary Melkumou 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State All Saints Cem. March 14, 1999 Reisterstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Eckhardt Funeral Chapel Stutt . & EAR 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical pulmonary condus -Examiner Due to (or as a consequence of): Examiner atters sclowing Cardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): wilva capcinoma Physician/Medical Due to (or es a consequence of): been signed by the s should be detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 5/2 chole cysfecting 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes el No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 -No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1-0 Natural 1 ☐ Yes 2 ☐ No 2 Accident **Director:** 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

68760 Records, Vital Attanding Physician: to Division 6 To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

RIMMA

EVAND ZHUNTSEV

altimore, Maryland 21215-0020

REEL

DHMH 16 Rev 6/95

after death.

State Registrar

Belveder 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

free s Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

CONSUEG

D: 44507

29d. Date signed (Month, Day, Year)

March

flumez, wo

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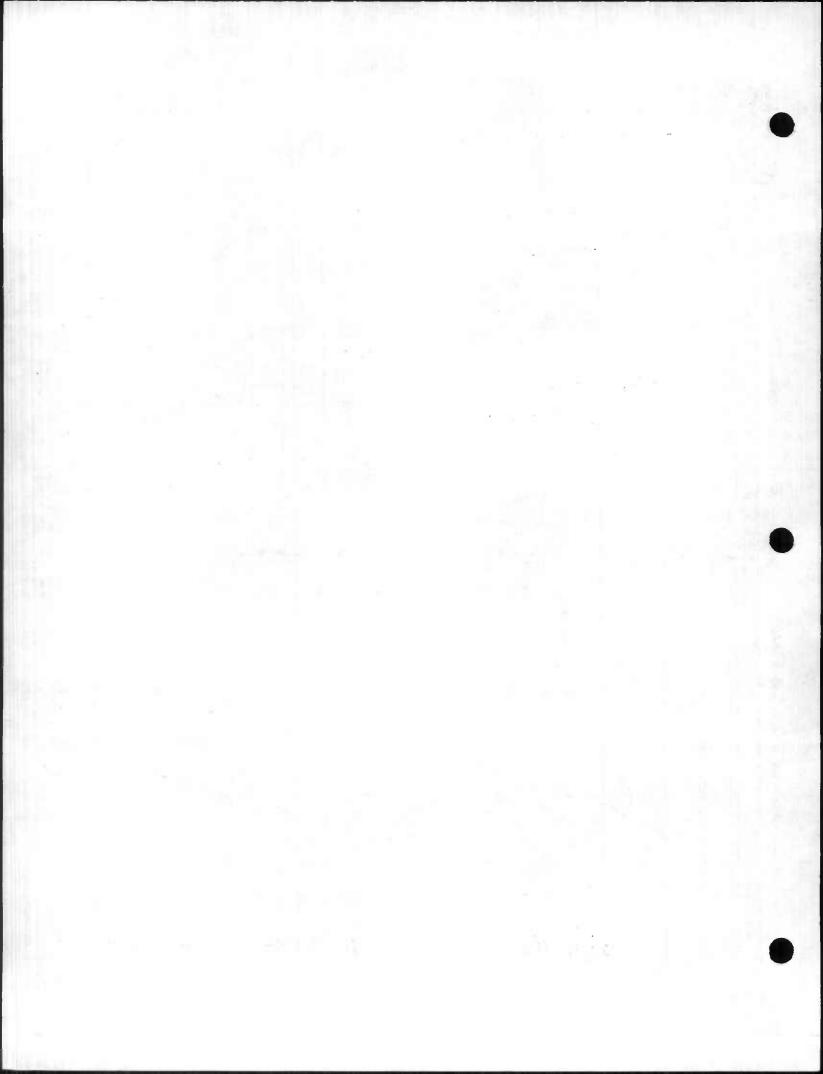
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** STELLA M. MARCH 15 1999 10:10 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CATON MANOR GENESIS ELDERCARE BALTTMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Hours Days Months 220-05-3647 92 Director Nov. 03 1906 Maryland Usual Residence of Decedent 10a Stata 10h Counts 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Co. Catonsville 1 ☐ Yas 2 ☑ No Director 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 115 C Osborne Ave. 21228 USA 'natural', or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Department Stores 0 Sales Clerk 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be permit. Pages 1 and 2 should be Department of Health and Mental important: if Item 27 is marked or any injury or other traumatic eve Charles L. Smith Teresa A. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) George Smith (Brother) 1508 Patapsco Street. Baltimore, Md. 21230 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) 3/19/99 Green Mount Cemetery Baltimore, Md 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 23a. Part Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Crassolnseum Examiner TEMOSCUERO The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medicai Dua to (or as a consequence of) P.O. been signed by the a should be detached i Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records. P Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 : OF No 2E No certificate 1 Yas 1 TYes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1- Natural 5 Panding investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 the the 29c. License number 29d. Date signed (Month, Day, Year) 0 ted cause of daath (Item 23a) (Type, Print) ANNAPOLIS ROAD 3927 HATTENJEE SHOKK

State Registrar 31. Date filed (Month, Day, Year) MAR 16

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 30PN AN HARRISS March 99 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) BALTIMORE HARBOK 5. Social Security Number ENTER BALTIMORE CITY If Under If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Days 1 M 2 XX 63 212-32-9275 12/13/1935 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No BALTIMORE CNTY BROOKLYN PARK 10q. Citizen of What Country? 10e. Street and Number 10f. Zip Code 613 HAMMONDS LANE 21225 U.S.A. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Never Married 2 Married Yes, Give 1 Yes 2 X No Specify: Specify: WHITE 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) DISABLED NEVER WORKED 12 18. Mother's Neme (First, Middle, Meiden Surname) Lunkina 17. Father's Name (First, Middle, Last) VANCE TROUTMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) GEORGE HARRISS - SON 8116 FORREST GLEN DR., PASADENA, MD 21122 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c Location - City or Town, State urial 2 Oremation 3 Removal from State LOUDON PARK CEMETERY 3/16 BALTIMORE. MD onation 5 Other (Specify) 22. Name and Address of Facility FINK FUNERAL HOME, P.A. of Funeral Service Light 426 CRAIN HWY., S.W. KELLY GREGORY GLEN BURNIE, MARYLAND 21061 Pert1. Enter the disease of complications that caused the death. Do not e shock, or heart failure. Le only one cause on each line. Approximete fnterval Between Onset and Death fm rediete Cause (Final dis se or condition dis se or condition resulting in death) XQCERBATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MON Due to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? 3 Probably Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medicai Examiner

The law requires that the death certificate be execu

signed by the

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certificate

this funeral

After

To the Mospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

by

Completed

Be

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Certification:

Medical

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or items 23s or 28s-f show

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parmit. Pages 1 and 2 should be filed within 72 hours effer Department of Neetth and Mental Hyglene. Important: if Item 27 is marked other than "natural", or ite

altimore, Maryland 21215-0020

Examiner buriel-trensit pue physician Physician/Medical the use es ed by the a

Pert II. Other algniffcant conditions contributing to death but not resulting in the underlying ceuse given in Part f.

25. Was cese referred to medicel

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

1 Yes 2 No 27. Manyfer of Deeth 5 Pending investigation Natural

28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier

2 Accident 3 Suicide

4 ☐ Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end menner es steted.

2 Medicat Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Dev. Yeer)

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who con pleted cause of deeth (Item 23e) (Type, Print)

tarbor Hospital

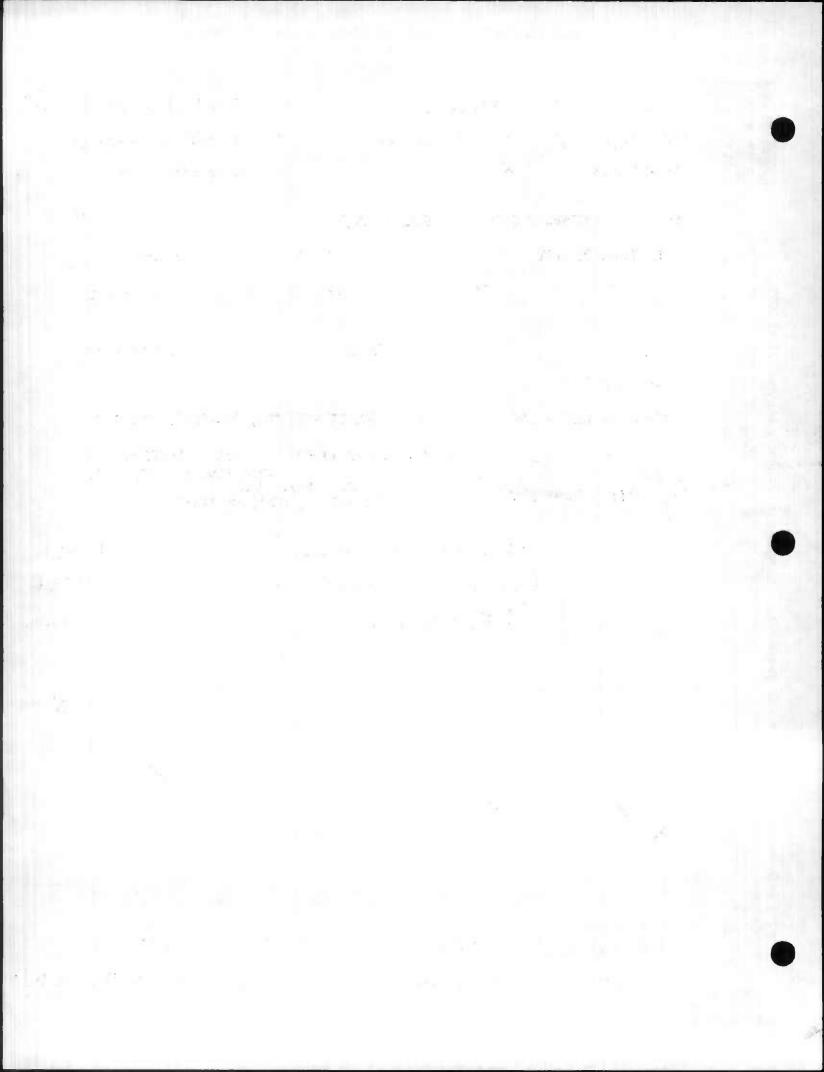
3001 S. Hanover Street Baltimore

State Registrar 31. Date filed (Month, Day, Yeer) MAR 1 6 1999



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95



		nd / Department of Certificate of			ene 9 9 g. No.	08193						
Decedent's Nema (First, Middle, La	st)			2. Date of Death Month	Day Year	3. Time of Death						
WILLIAM J. HOFF,	111			march	11 199							
4e Facility Neme (If not institution, giv			4b. City, Town, or		4c. County of De							
North Acunc			6 en B		-	Arundel						
5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs. Worths Days Hours Min. Usuel Residence of Decedent 9. Birthplace (State or Forei Country) 9. Birthplace (State or Forei Country) 9. Birthplace (State or Forei Country)												
10a. Stata 10b. County		10d. Inside City Limits										
MD AACo	G	olen Burnie				1 ☐ Yes 2 ☑ No						
10a. Street and Number		10f. Zip Cod	le	10	g. Citizen of What 0	Country?						
	- Rd	210	60		USA							
11. Maritei Status 1 Never Married 2 Married	12. Wes Decedent Evar in U Armeti Forces?	I,S. 13. Wes Decedent	of Hispanic Origin? (S Cuban, Mexican, Puer	specify Yes or No-	14. Race - An Black, Wh	nerican Indian,						
1 ☐ Never Married 2 ☐ Married	1 1 Yes 2 □ No			to ruceri, otc.)								
3 Widowed 4 □ Divorced	If Yes, Give Yaar or Detes: 53-50				Specify: u							
15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Decedent's Usuel Oc (Give kind of work do life. DO NOT use re	one during most of wa	rking	6b. Kind of Busines	s/Industry						
15. Decedent's Ed. (Specify only highest grate Elementery/Secondary (0-12) 17. Fether's Neme (First, Middle, Last, Middle, Last, Middle, Last, Middle, Last, Middle, Last, Middle, Last, Middle, Midd	Coilege (1-4or 5+)	Fire Fight			Bultimon	e Citu						
17. Fether's Neme (First, Middle, Last,)	3		me (First, Middle, N								
William J. Hoff	II		Flossy									
19e. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Str		,,,,,,	City or Town, State	Zip Code)						
	Daughter	1019 Bell Ave	e Glen Bur	nie mo	21060							
20a. Method of Disposition	The second secon	Plece of Disposition (Name of cemetery, crematory or other		Date 2	Oc. Location - City of	or Town, State						
1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specif	Hemoval truth State	ultimore nati		3.15.99 1	3altimor	e, md						
23e. Part1. Enter the disease, or come shock, or heart fellure. List one Immediate Ceuse (Finel disease or condition	plantions that caused the deep cause on each line.	Tolo Cro		c or respiratory erre		Approximate interval Between Onset and Death						
resulting in death)	Due to (c	or es e consequence of):	2/	1	2	1 4 01/23						
Conventially lies agaditions	b. Antspose	I STOTIC CEN	renny /7	MELLY !	45848	YEars						
if any, leading to immediate	Due to (c	or es e consequence of):										
	c. DAMBETE	is MELLET	us		31 DV V	YEARS.						
cause. Enter Underlying Cause (Diseese or injury	Dua to (c	or es e consequence of):				YEARS!						
cause. Enter Underlying Cause (Diseese or injury that initiated avents resulting in death) Last	1 TYPSRTS	NS FON				YEARS						
cause. Enter Underlying Cause (Disease or injury thet initiated avents resulting in death) Last												
Cause. Enter Underlying Cause (Disease or injury thet initiated avents resulting in death) Last	entributing to death but not you	ulting in the undertring source	divon in Red I	22h Did to	hacco una contribu	to to the cause of death?						
Cause (Disease or Injury that infilted avents resulting in death) Last Pert II. Other significant conditions of	ontributing to deeth but not res	sulting in the underlying cause	given in Part I.			ne to the cause of death? Probably 4 Unknown						
Cause (Disease or injury that initiated avents resulting in death) Last Pert II. Other significant conditions of	ontributing to deeth but not res	sulting in the underlying cause	given in Part I.		a autopsy 248							
Cause (Disease or Injury that infilted avents resulting in death) Last Pert II. Other significant conditions of	ontributing to deeth but not res	sulting in the underlying cause	given in Part I.	1 € Ye 24a. Wes ar	a autopsy 24th	Probably 4 Unknown D. Were autopsy findings available prior to completion of cause of death?						
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Division of Vital Records, P.O. Box 68760, To the Ho within 24 I To the Fu 10+1

殿 State Registrar

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

DAV 25 PC54, M.O., SULTE SUU DOU | U 8774,

31. Date filed (Month, Dey, Year)

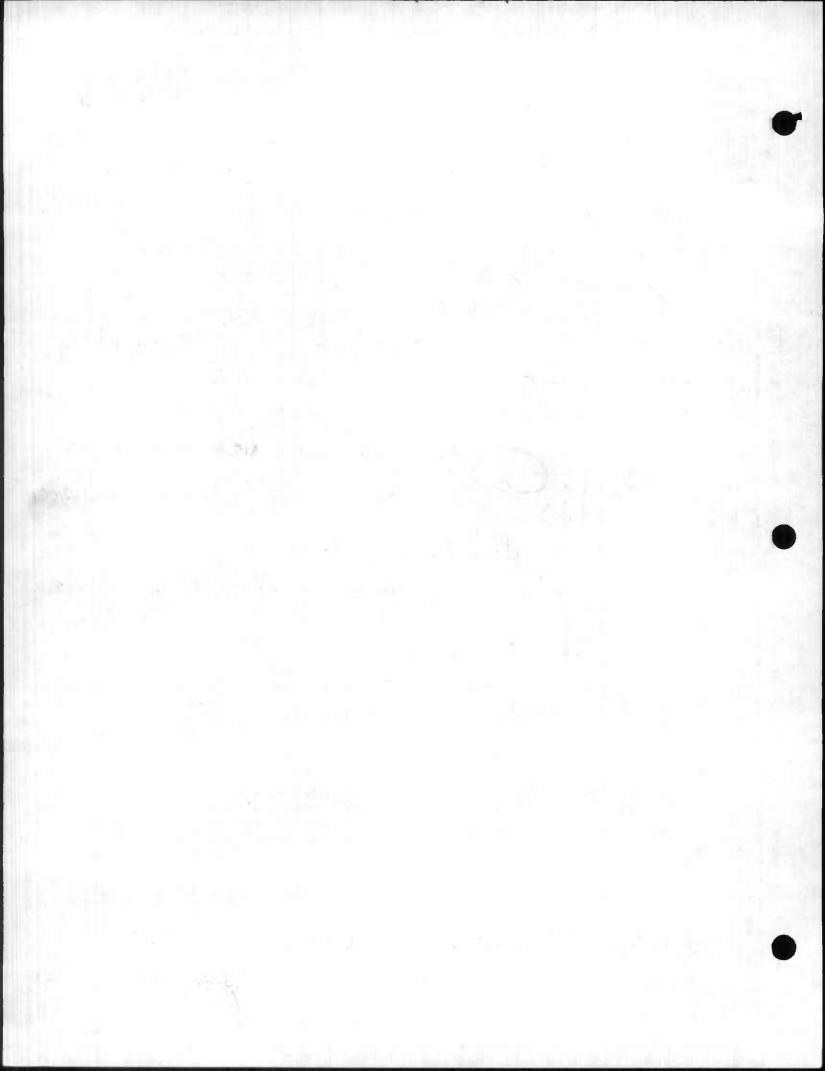
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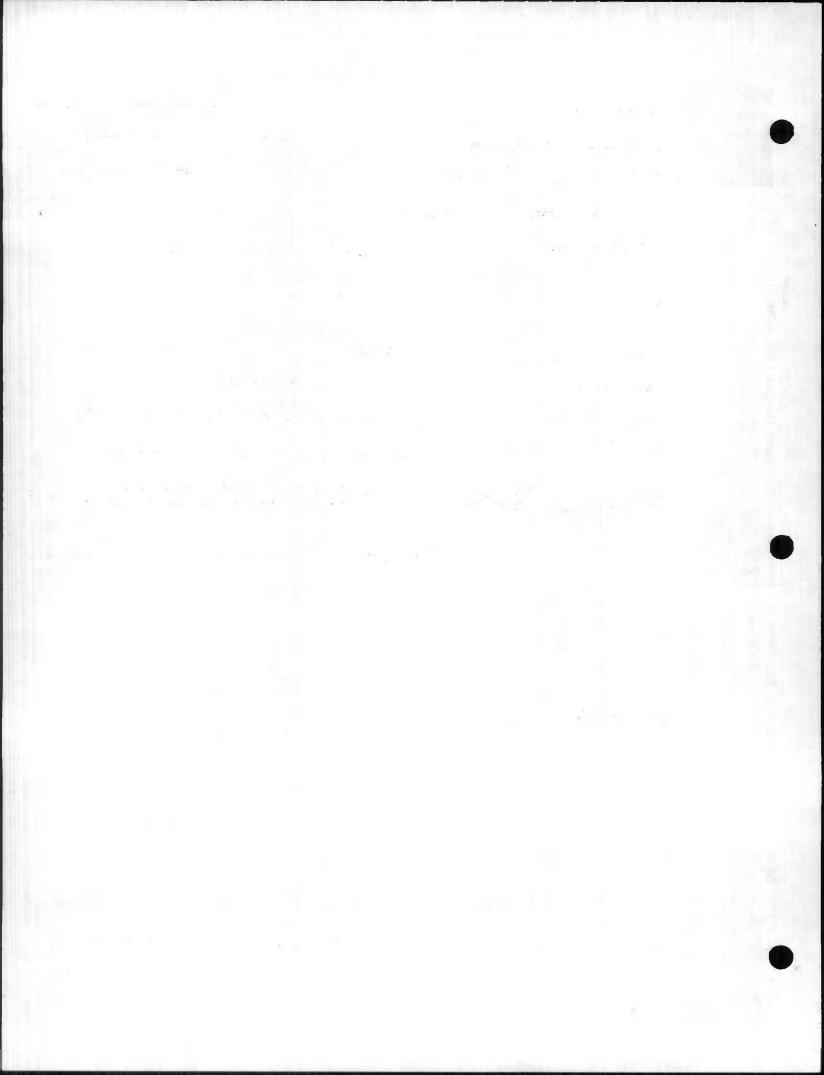
29c. License number

29d. Date signed (Month, Day, Year)



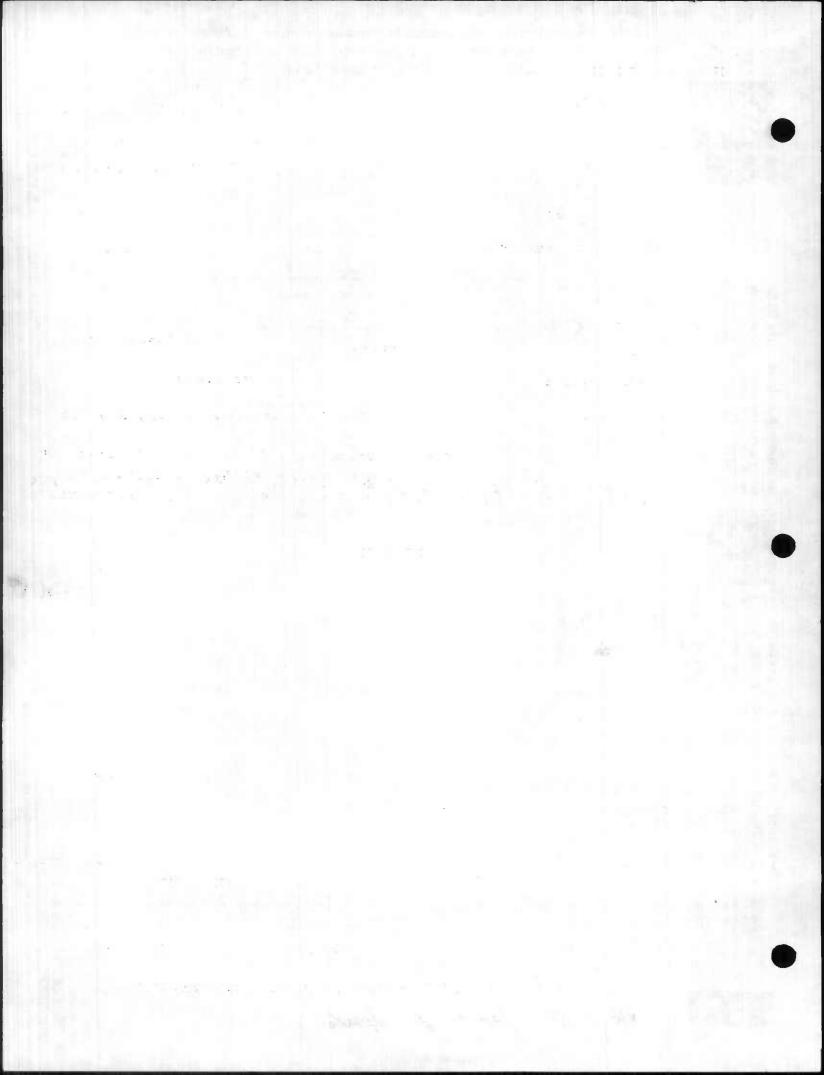
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						Cert	ificate o	f Death		,	Reg. No.	UC	174	
	Dhuriai		1. Decedent's Name (First, Middle, Last,)						Dete of Dea		Year	3. Time of Death	
	Physici /Medic		Mildred K. Hook					M	March 10, 1999		9	1:15 PM		
	Examin	er	4a Facility Name (If not institution, give		4b. City, Town		on of Death		4c. County of Death Baltimore					
			Ridgely Manor Nurs 5. Social Sacurity Number 6. Sec		(In yrs. last b	irthday)	If Under 1 Ye	Balti ar If Under 24		Date of Birtl				
	Funeral Director			THE OFFICE	96	Yrs.	Months Day			27057	1902		place (State or Foreign ptry) pland	
Maryland 21215-0020	a-f ahow	by Funeral	Maryland Baltimor	re	10c. City, Town or Location Baltimore							1	0d. Inside City Limits 1 ☐ Yes 2 1 No	
	ath with the Merylen 23a or 28a-f ahow		10e. Street and Number 611 Coleraine Road				10f. Zip Code 21229				10g. Citizen of What Country? USA			
	n 72 hours efter dea "natural", or Nems		11. Maritel Status 1 Never Married 2 Married 3 Noticed	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		lf	as Decedent of Yes, specify C	of Hispanic Original Specify:	n? (Specify Puarto Rica	Yes or No- n, etc.)	Blac	e - Americ ck, White, White	etc.	
	THE R. LEWIS CO., LANSING, MICH.	Completed	15. Decedent's Edu (Specify only highest grade Elemantary/Secondary (0-12) 10th	cation e completed) College (1-4or 5-	+)	(Give k	O NOT use ret	ne during most o	during most of working			16b. Kind of Business/Industry Homemaker		
yland	71 72 40 0	To Be C	17. Father's Name (First, Middle, Last) Millard Hardy					Nama <i>(Fii</i> lia Ha		Maiden Suman	10)			
	d 2 sh th end 7 is m traum		19a Intormant's Name/Ralationship (Ty Leroy Hook Jr./Son	pe, Print)	6	11 C	olerai	ne Rd. E						
Baltimore,	m tof		20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lamoval from Stata	cemen	ery, cremi	ition (Name of atory or other p dral Co	olace) emetery		3/99	20c. Location - Maryl	_	own, Stete	
Balt	permit. Pe Department Important: any Injury once.		21. Big thurs of Funeral Service Liberson 23a. Parl 1. Enter the disease of complishook, or heart tailure. List only or	mobile	the death. Do	Da 53	vid J.	dress of Facility Weber Fondson A fyling, such as ca	venue	Balt	imore,	A. Mary	land 21229 Approximate Interval Between	
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68760,	rificete be executed ng physician end es the buriel-transit	dicai Examiner	Sequantially list conditions, If any, leading to Immediate cause. Entar Underlying Cause (Disaase or injury that initiated events resulting in death) Last		Oue to (or as a									
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s, P.O.	requires that the desent signed by the e	by Physician/Medical	Part II. Other significant conditions con Democratic	itributing to death but	t not resulting	in the und	derlying causa	givan In Part I.		23b. Did t	>		the cause of death?	
Records,	ew requi	Completed								24a. Was perfo	an autopsy med?	ev	ara autopsy tindings ailable prior to mpletion of cause daath?	
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ion of Vital	ling Phys	To Be	25. Was case raterred to medical examiner? 1 Yes 2 No 27. Manner ot Death 1 Natural 5 Pending investigation	lospital: 1 Inpatien 28a. Data of Injury (Month, Day		Outpatient Time of Injury	28c. Ir	26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Special Special Speci			(y)			
Division	To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28a. Place of Injurbuilding, atc.	ry - At homa, ((Specify)	tarm, stra	at, tactory, office				off. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of nar: On the basis of and manner stat	examination a	ge, death nd/or inve	occurred at the estigation, in m	time, date and y opinion, death	place, and occurred a	due to tha d t the tima, d	causa(s) and madata and place,	annar as s and due to	tated. o the causa(s)	
	To the vithin comp	M	29b. Signature and title of certifier	eya MD		29c. License number 27541					29d. Date signed (Month, Day, Year) March 12, 99 Belt, MD-21227			
7				mpleted cause of de	567	Hol	11hs:	Ferry	Rd	B	alt, 1	10.	21227.	
	Sta Registr		31. Date tiled (Month, Pay, Year)	Sew		1.	pour							
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ner	4a Fecility Neme (If not instituti			4b. City, Town, or Location of Deeth 4c. County of Deeth							
	UNIVERSITY HOS		T	1 - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year	BALTIMO If Under 24 Hr		N/A			
	5. Sociel Security Number 213-54-4104	6. Sex 1 M 2 □ F	7. Age (in yrs. 4.7	. last birthday) Yrs.	Months Deys	Hours Mir		7.1951	9. Birthpiece (Stete or Foreign Country) Maryland		
_	10s. State 10b. Count								10d. Inside City Limits		
Director	MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code							10g. Citizen of V	12 Yes 2 No Whet Country?		
Funeral Di		CKER ST	REET	1217		-	. A .				
2	11, Merital Stetus 1 Never Married 2 Ma 3 Widowed 4 3 Divorce	Armed F	2K No live		Vas Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispenic Origin? (pen, Mexicen, Pue Specify:	Specify Yes or No rto Ricen, etc.)	Specify	e - American Indien, k, White, etc. Black		
	15. Decede (Specify only high	nt's Education est grade completed	0	16e. Deced	ent's Usuel Occup	pation during most of world)	orking	16b. Kind of Bu	siness/Industry		
	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)		orer	iu)		Cons	truction		
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To	19e. informent's Neme/Reletior Eddie Harr					t and Number or F			Stete, Zip Code) 1 a n d 2 1 2 0 7		
	20e. Method of Disposition 1 Buriel 2 Cremetion 4 Donetion 5 Other (. 01-1-	cemetery, cren	sition (Name of netory or other ple MOTIAI	Park 3	Date / 19/99		City or Town, Stata 1 stown, MD		
	21. Signature of Funeral Service	E Libensae	muel						$E^{L}L$ J^{R} . $P.A$. $ALTO.$, $MD2120$		
	immediate Ceuse (Finet disease or condition resulting in death)	e	Due to (or es e consed	uenca of):						
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							24e. Wes	s en eutopsy ormed?	24b. Wera eutopsy findings aveilable prior to completion of cause of death?		
							12	Yes 2□No	1 ₹ Yes 2□ No		
	25. Wes case referred to medic examiner?						eath (Check only	one)			
	XXYes 2 No			ER/Outpatien	1 3LI DON		Home 5 ☐ Res				
Cathon	Z L Accident	tigation UNKNO	nth, Dey Year)	28b. Time of injury UNKNOWN	28c. inju Wo	rk? Yes 2 No	UNKNOWN	28d. Describe how injury occurred UNKNOWN			
	3 ☐ Suicide 4 ☐ Homicide 6 ☑ Could not be determined 28e. Pleca of injury - At home, farm, street, fectory, of building, efc. (Specify) FOUND: HOME						28f. Location (Street and Number or Rural Route Number City or Town, Stete) 510 N. STRICKER S				
en	29a. Certifier 1□ Certify		e best of my kno basis of axamin	owiedge, deeth			ca, end due to the		enner as stated.		
	(Check only XX Medica	one) and menner steted.						29d. Date signed (Month, Dey, Year)			
edicai	(Check only XX Medica	to the same of the	*		29c. Licen	se number		MARCH 6, 1999			
Medical Certification:	(Check only Medica one) Medica 29b. Signature and title of certifications	or No.	1	- 00c) T	001						
edicai	(Check only None) Medica	or No.			OCI		e_Maryl	MARCH 6	, 1999		



Physician /Medical Examiner

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumetic event, the Medical Examinat must be notified a page.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

-033 Pleas	e Type or Prin					•	_	lble.		
Item:20b per F.H G-	State of Ma		Certifica			i Wellal II	22	08196		
1. Decedent's Name (First, Middle,		20	Certifica	ale or	Dealli	2. Date of D	Reg. No.	3. Time of Death		
Pamela Kay						Month	Day	Yeer		
4a Facility Name (If not Institution,		У			4b Ciby Town	FEBRU. or Location of Dea		19991610 PM		
HARMONY MEMOR		семета	PV		ANDOVE			CE GEORGES		
		e (In yrs. last bii		der 1 Year	If Under 24 H	rs. A Date of B	irth			
224-19-5355 Usual Residence of Decedent	1□ M 2ÅF		Yrs. Month	ns Days	Hours M	in. (Month. D	Dav. Year)	9. Birthplace (State or Foreign Country) Beckley, W.Va.		
10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits 1 1 1 Yes 2 □ No		
Maryland Prince	George's	Oxon H	i11							
10e. Street end Number			10f.	Zip Code				What Country?		
504 Wilson Brid				20745				d States		
11. Maritel Status 1 □ Never Married 2 □ Married 3 ➡ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1				lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	Bla	ce - American Indian, ack, White, etc. fy: WHITE		
15. Decedent'a (Specify only highest g Elamentary/Secondary (0-12)	Educetion grade completed) College (1-4or 5	16a	Decedant's U (Give kind of life. DO NO	sual Occup work done Luse retire	pation during most of v	vorking	16b. Kind of E	Business/Industry		
11	0011090 (1 407 0		Mail De	signe	r		Priv	ate		
17. Father's Name (First, Middle, La William A. Shi					18. Mother's N Mary L	lame <i>(First, Middl</i> 111v	le, Maidan Suma	me)		
19a Informant's Name/Relationship William A. Shre	(Type, Print)				and Number or			n, State, Zip Code) ia 25801		
20a. Method of Disposition 1 Buriel 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cemete	f Disposition (I	or other pla		3/16/99 3/3/99		- City or Town, State		
23a. Part 1 Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final disease or condition rasulting in death)	Aunas		Alex 5538 not enter the m	ander Marl node of dyir	boro Pi		tville,	Maryland 20747 Approximate Interval Between Onset and Death		
Sequentielly list conditions, if any, leading to immediate	b	Due to (or es e	consequence	of):						
cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as e	consequence	of):				1		
Part II. Other significant conditions	contributing to death bu	ut not resulting i	n the underlyin	g ceuse giv	ven in Part I.		d tobacco uae c □ Yes 2 □ No	ontribute to the cause of death?		
						per	as an autopsy normed?	24b. Were autopsy findings available prior to completion of ceuse of daath?		
25. Was casa rafarrad to medical examiner? 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Hospital: 1 ☐ Inpatie	int 2 ER/O	utpatient 3	DOA Oth	or:	Death (Check only		ther (Specify) AT SCEN		
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not determine	28a. Date of Injunction 2 4 9	y Year) 28b.	Time of Injury	28c. Inju Wo 1 tory, office		28d. Describe how injury occurred				
	hysician: To the best of	of my knowledge examination an	e, death occurr	ed at the tir		ice, and dua to th	e cause(s) and n			

Medical Certification: To Be Completed by Physician/Medical Examiner within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funaral director, page 2 should be deteched for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

State Registrar

30; Name and address of person who complated ceusa of death (Itam 23a) (Type, Print)

111 Penn

31. Date filed (Month, Day, Year)

32. Registrar's Signature

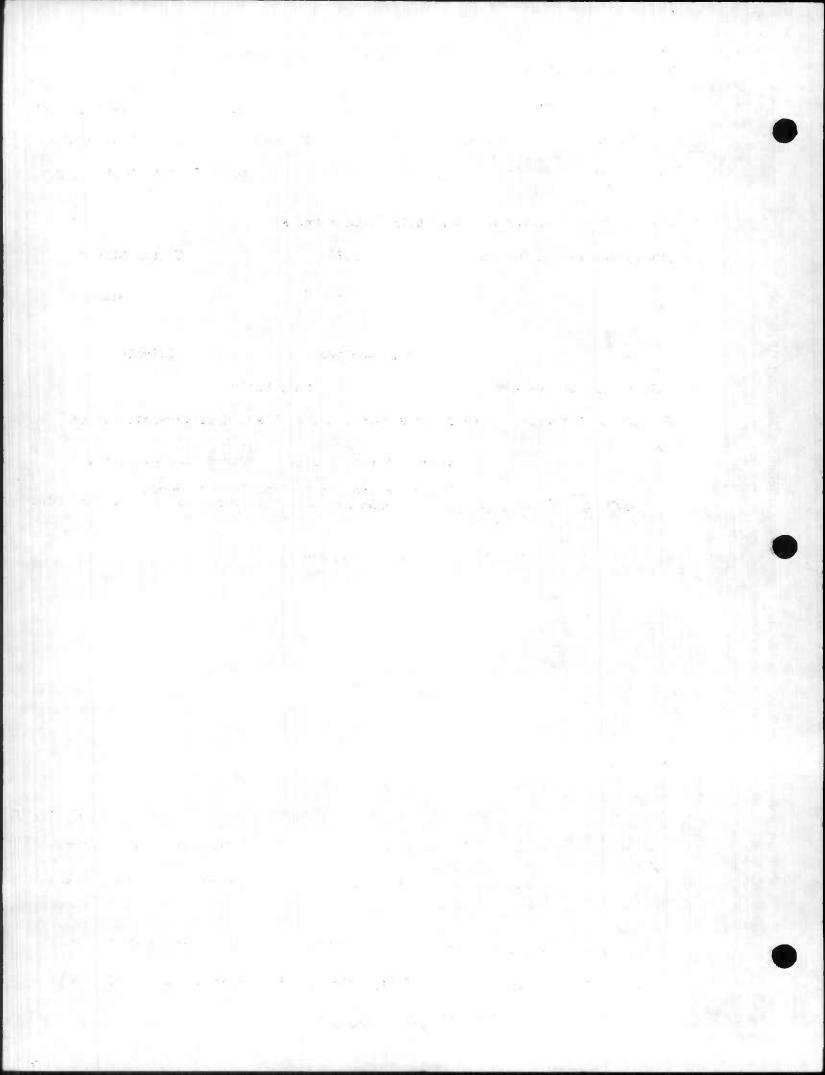
111 Penn Street, Baltimore, Maryland 21201

FEBRUARY 5,

1999

OCME

DHMH 16 Rev 6/95



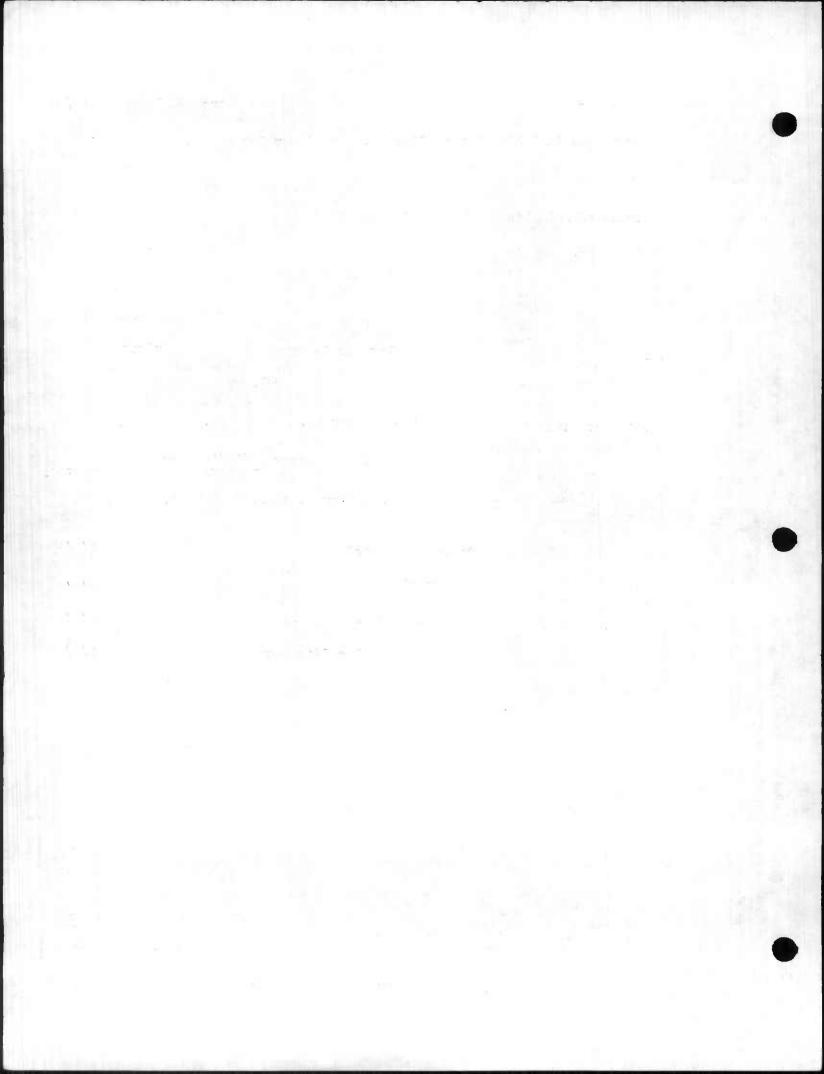
Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death March 9, 1999 Physician 6:02pm Rosetta Johnson /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Holy Cross Hospital 1500 Forest Glen Rd. Montgomery Silver Spring, MD If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country)
 A **Funeral** Days 98 Yrs. Director 577-60-5373 Loundon County Usual Rasidenca of Decedant death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show The Medical Exerciper must be notified at 1 X Yas 2 □ No Director District of Columbia Washington, DC 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2125 7th St., NW Apt. 513 20001 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event, the Mental Exertination. Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva 1 Navar Married 2 Married 1□ Yes 2₽No Baltimore, Maryland 21215-0020 Specify: Specify: Black by Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Private Elevator Operator 12th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Unknown Unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 503 Decatur St., NW Wash., DC 20011 Otis Moore/cousin 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 Donation 5 Other (Specify) 3/13/99 Laurel, MD Maryland Nat'l Cemetery LATNEY'S FUNERAL HOME, INC. to of Funeral Be 22. Nama and Addrass of Facility vice Licenses Okllem 741 3831 Georgia Ave., NW Wash., DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or ly one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediata Causa (Final 1/9/99 Acute Pneumonotis disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner Dehydration 1/9/99 attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or trijury that initiated evants resulting in death) Last Due to (or as a consequence of): 1/9/99 Records, P.O. Box 68760, Congestive Heart Failure Physician/Medical Dua to (or as a consequence of): Chronic Renal Insufficiency 1/9/99 signed by the at d be detached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown **HBP** ASCVD p 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 □ Yas 2 □ No Division of VItal Hospital or Attending Physician: Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 XNo Medical Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Naturat 5 Pending death. 1 ☐ Yas 2 ☐ No 2 Accidant invastigation hours after death 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Ptace of Injury - At homa, farm, street, factory, office building, atc. (Specify) completely filled in by 4 Homicida 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the To the To the 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) M ahuh D 17729 March 10, 1999 REST 30. Nama and addrass of person who complated causa of death (ttem 23a) (Type, Print) 20910 George B PATRICK IT Silver Spring, MD 9221 Colesville Rd. 31. Date filed (Month, Day, Year) MAR 1 6 1999

DHMH 16 Rev 6/95

State Registrar 32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death OHNSON Month Yeer **Physician** AROTHYMAE MARCH 45 am 1999 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore NA If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthpiece (Stete or Foreign Country) **Funeral** Deys Hours 1 M 20 F 77 Yrs 06-06-21 Director 214-14-3030 VA Usuel Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f ahow traumatic event, the Medical Examiner must be notified at MD Yes 2□No NA Director Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1300 E. Lanvale Street Apt.508 21213 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. nit. Pages I and 2 should be filed within 72 hours efter of artment of Hauth end Mentel hygiene. ortant: If Item 27 is marked other than "natural", or Item Injury or other traumatic event, the Medical Experiment injury or other traumatic event, the Medical Experiment. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ XIXWidowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry rede completed) Elementary/Secondery (0-12) 10th Grade College (1-4or 5+) Domestic other people homes 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 0 William Jennings Jennings Cordie 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 3247 Pelham Avenue Baltimore, Md. 21213

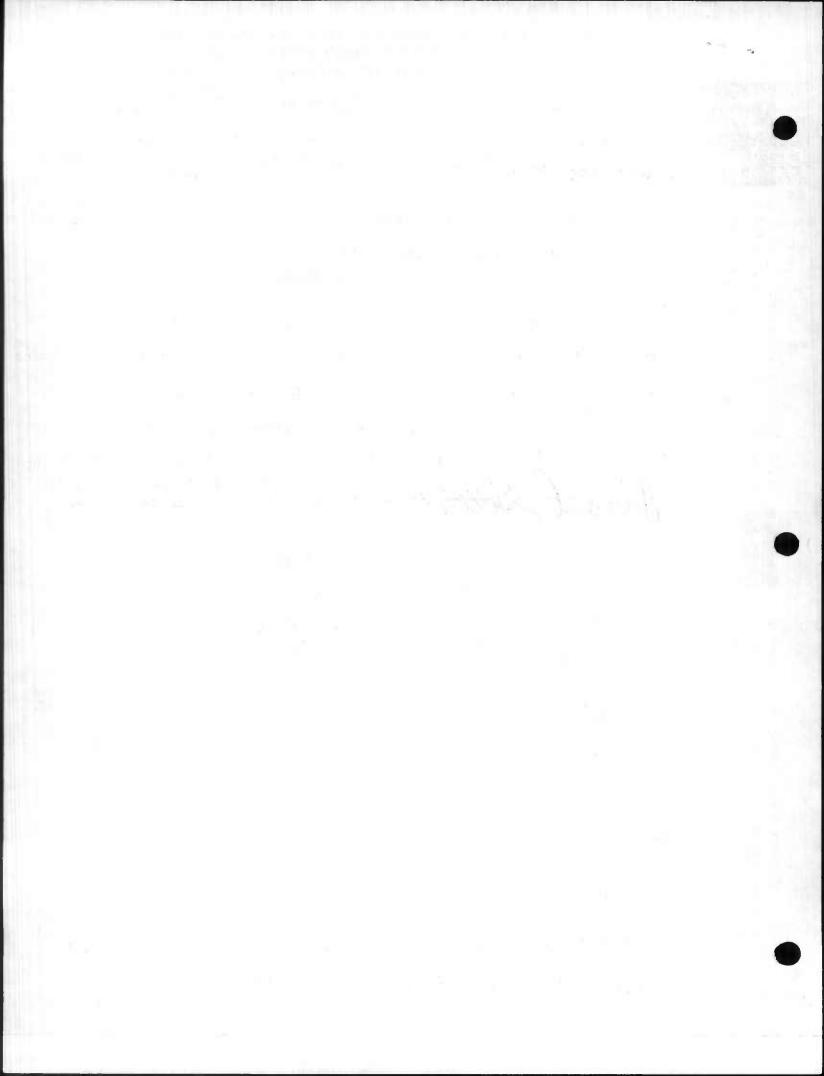
f Disposition (Neme of Dete 20c. Location - City or Town, Stetem D Shirley McDuffie 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 Donetion 5 Other (Specify) Baltimore Nat'l Cemetery 03-03-18-99 Baltimore 22. Name end Address of Fecility Baltimore, Maryland 21202 21. Signeture of Funeral Servica Licente WM.C.March FH 1101 E.North Avenue Do not enter the mode of dying, such es cardiec or respiretory errest, ase, or emplications that feilure. List only one cause on Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and Records, P.O. Box 68760, ed by the attending physician deteched for use es the buna Due to (or as e consequenca of): Physician/Medical Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 □ Probably 4 ☑ Whknown þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Was en eutopsy peen has 2 No this certificate 1 Yes 1 ☐ Yes 2 No Division of Vital Attanding Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Impatient 2 ER/Outpetient 3 DOA funeral 28a. Dete of Injury (Month, Dey Yeer) 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1 Maturel 5 Pending investigation daath. 1 ☐ Yes 2 ☐ No To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner steted. edicai 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature end title of cartifier 29c. License number 30. Name end pleted cause of death (Item 23e) (Type, Print) Baltinore MD21239 LOCRKOVEN Blud 5601

32. Registrer's Signeture

Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month March 8, 1999 Ralph E. Jones 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death

Silver Spring

Physician /Medical Examiner

Fox Chase Rehabilitation

Funeral Director

ed other than "natural", or items 23s or event, the Medical Exempler must be r "ristursi", or Hygiens. ther than

should be filed within th and Mental I Pages 1 and 2 a ment of Health an ant: If Item 27 la 1 Department of Important: If It any injury or o

Physician /Medical Examiner

The law requires that the death certificate be executed and -trans ettending physician à or Attending Physician: funerai 24 hours after death.

Funeral Director: After within 24 hor To the Fune completely fi

by

Be Completed

2

Certification:

edicai

State

8. Data of Birth (Month, Day, Year)
Nov. 26,1913 If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 6. Sax 1 M M 2 □ F Days Hours Min 85 Yrs. Pennsylvania 215-38-9165 Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location Anne Arundel Laure1 Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3397 Fountain Green Street 20724 USA Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black, White, atc. 1 ☐ Yas 2 ☐ No If Aes, Giva Yaar or Datas: 1 Never Married 2 ☐ Married 1 Yas 2 No Specify: ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) Golf Course Superintendant Ft. Meade Golf Course 12 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be Harry Jones Maud C. Roberts 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19s. Informant's Name/Relationship (Type, Print) Alva G. Dedeaux/Friend 3396 Fountain Green St., Laurel, Maryland 20724 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 3/24/99 5 Dilher (Specify) Arlington National Cem. Arlington, Virginia Donation-21. Signature of Juperal Standon Lioung 22. Nama and Addrass of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Sease, or complications that causad the death. Do not enter the mode of dying, such es cardiec or respiratory errest,

Approximate

Approximate y ocordial Inforction Immediata Causa (Final disaasa or condition resulting in deeth) Examiner Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiac arrythmias, vesico colic fustala, sigmoidedon Pulmorary embolism, VRE of abdomind wound, Cholecrstertay,

23b. Did tobacco usa contribute to the cause of death?

3. Tima of Death

10d. Insida City Limits 1☐ Yes 2X No

White

Approximate Interval Batween Onsat and Death

Seconds

Montgomery

7:00 a.m.

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

24b. Wara autopsy findings evalleble prior to completion of causa of death? 1 Yes 2 No 1 ☐ Yas 2 No

March 11, 1999

Greenfield filter, Castroslong, PEG tuke, Indwelling Folers
25. Was case ratarred to madical axaminar?

Hospital.

Hospital. 26. Place of Death (Chack only ona) Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yas 2 No 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Daath 28b. Tima of 28d. Describe how injury occurred 5 Panding investigation 1 Natural
2 Accidant 1 ☐ Yas 2 ☐ No 6 ☐ Could not be datarminad 3 Suicida 28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Spacify) 28f. Location (Streat end Number or Rural Route Number, City or Town, Stata)

4 ☐ Homicida 29a. Cartifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.
2 Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Yaar) 29b. Signature and titla of certifier

Doo 52255

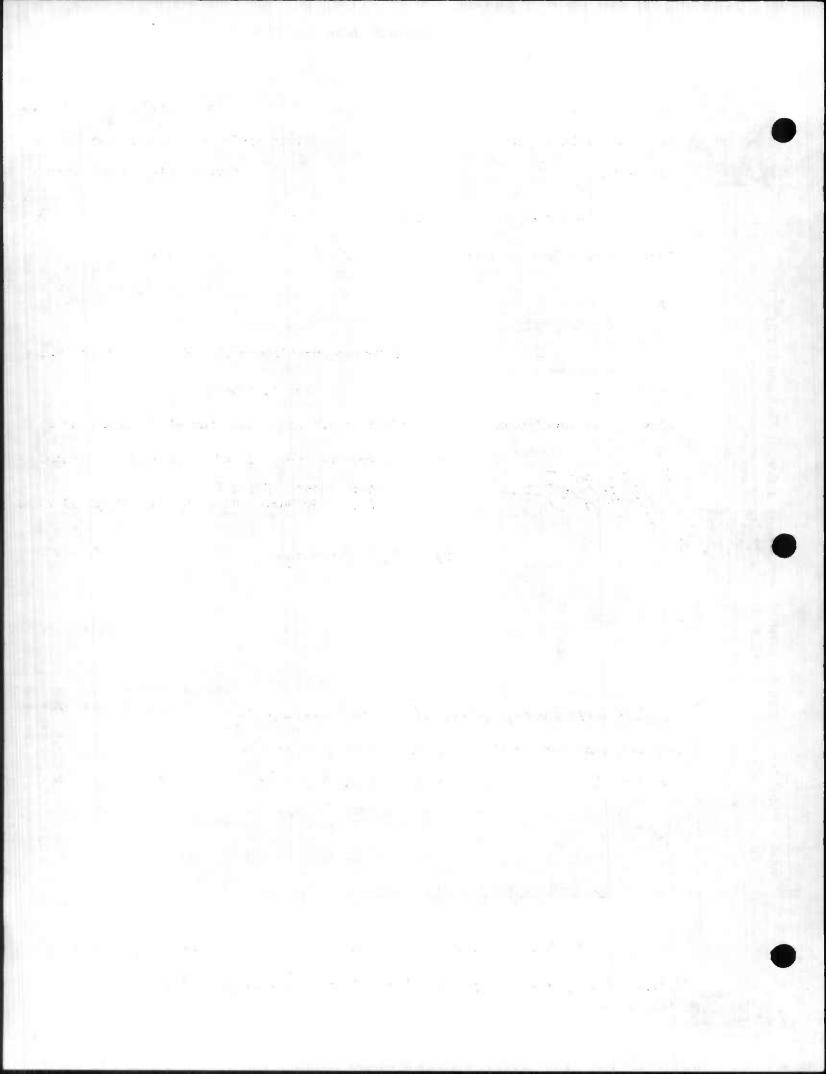
30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

Ave #404B Silversfring, MD 20910 8609 2nd Muhammad Eigz M.D

poorly

31. Pate filad (Month, Day, Year) MAR 1 6 1999 32. Registrar's Signature

Registrar



ate of Maryland / Department of Health an Certificate of Death	2 2	08201
Certificate of Death	Reg. No.	
	2. Date of Deeth	3. Time of

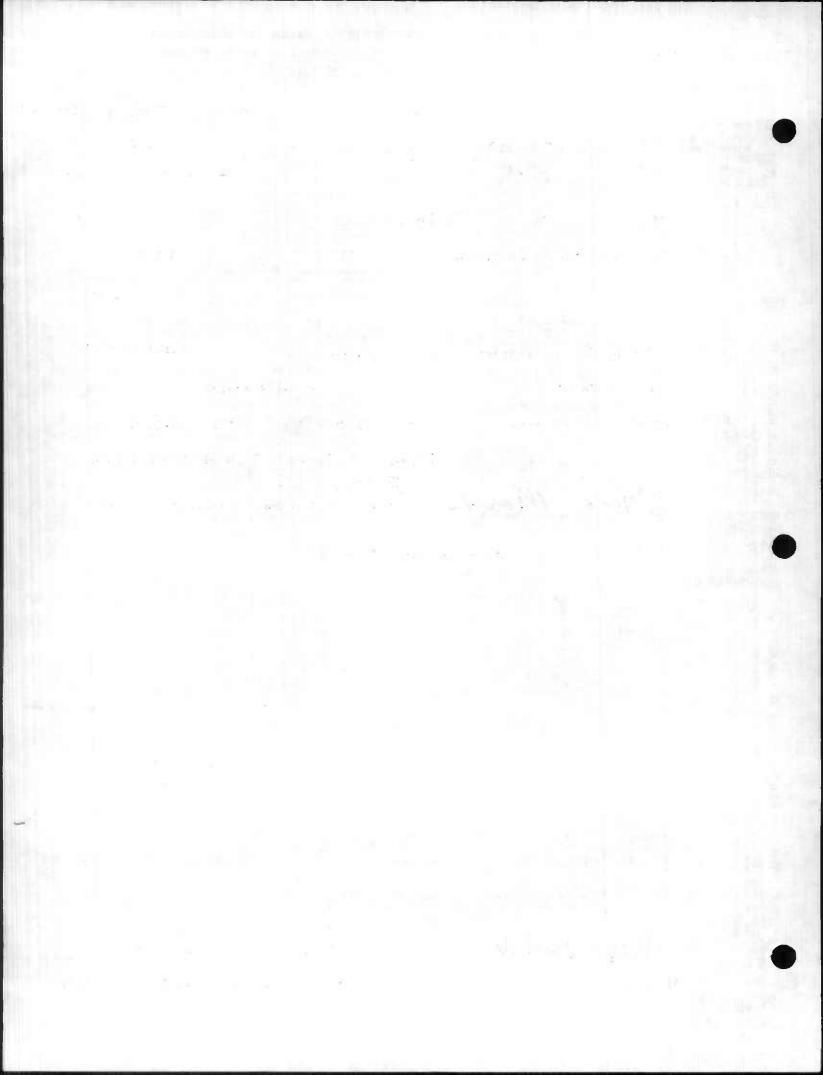
Physician · /Medical	1. Decedent's	Neme (First, Middle, L	ast)								
* /Medical							2. Date of D	eeth Day	Ye		me of Death
			Christi	ine E.	Johnson		March		1999		1:54 P.N
Examiner	4a Facility Na	me (If not institution, g	ive street and numbe	r)		4b. City, Tow	n, or Location of Dea	th 4c.	County of D		
	3902	Hilton Str	eet, Apar	tment 3	354		ltimore		N/A	2	
Funeral Director	5. Social Secu. 219-80-		Sex 7. A	age (In yrs. las 37	t birthday) If Un Yrs. Mont	der 1 Year If Under 24 hs Days Hours	Min. (Month, D	irth lay, <i>Year)</i> -1961	9.	Country)	itate or Foreign
pur *	Usual Residen	10b. County		10c. City. T	Town or Location					10d. Insi	ide City Limits
the Merylar 28a-f ahow corrector	Md	100	/A		imore						Yes 2□No
28a- 28a- 28a-	10e. Street and		/ ^	Dare		Zip Code		10a. Citiz	zen of Wha	t Country?	
ther death with the Mer ritems 23e or 28e-fai inserment be notified funeral Director		Hilton Str	et Apartm	ent 35		21215		U			
re 2:	11. Meritel Sta					cedent of Hispenic Origination Cuban, Mexican,	in? (Specify Yes or N		14. Rece - /	Americen Indi	en,
0 05	1 🖔 Never	Married 2 Married	12. Was Deceder Armed Forces 1 Yes 2 V If Yes, Give Year or Detes			s 2 No Specify:	Puerto Ricen, etc.)			White, etc. Black	
2 ho		15. Decedent's	Education		16a. Decedent's U	Isual Occupetion	of working	16b. Ki	nd of Busine	ess/Industry	
		Specify only highest g Secondary (0-12)	College (1-4o	r 5+)		work done during most of T use retired)	or working	11	+ h C = -		
Hygiene. Hygiene. Ther ther Ant, the leart, the lear	12tr	n grade	2 years		Super	- T				rvices	
should be filed within 72 hours with Mantal Hyggene. marked other than "natural; imatic event, the Magerille. To Be Completed by		eme (First, Middle, Las	st)				's Name (First, Middl	e, Maiden	Sumame)		
2 should be f and Mental is is merked of raumatic eva To Be		E. Johnson					ie Mobley			Charles The Constitution	
		t's Neme/Relationship				ess (Street end Number					
of Heelth of Heelth I Item 27 r other t		lie Johnson	1 -Mother	OOb Dies	3530 Ke	source Driv	e Randal			21133 y or Town, Ste	
	20a. Method of	Disposition 2 Cremation 3	Removel from Stat	cem	etery, crematory	or other place)					
Partition of the same of the s		tion 5 Other (Spec		K1		ial Park	3-18-99	Ran	dalls	town,	Md
permit. Pag Department Important: If any injury o ance.	1	of Funerel Service Lic	1. 1	1	Man	and Address of Fecility Ch F/H West					
00580	0	John	1Vari	h	4300	Wabash Ave	nue Balt	imore	. Md	21215	
	23a. Part1. Er shock, or	nter the disease, or co r heart failure. List on	mpiications that caus y one cause on each	ed the death. line.	Do not enter the r	Wabash Ave	ardiac or respiratory	arrest,	,	Appro	ximete al Between
Physician										Onset	and Death
/Medical Examiner	Immediate Ca disease or cor resulting in de	ndition	Cong	enital	Heart D	isease					
100	resulting in de	eatri)		Due to (or a	s a consequence	of):				1	
ficate be executed physician and st the bunal-transit edical Examiner			b								
certificate be executed rightly physicien end use es the burial-transit n/Medical Examir	Sequentially lift any, leading cause. Enter Cause (Disease)	ist conditions, to immediate		Due to (or e	s a consequence	of):					
be e siclen buris	Cause (Disease that Initiated e	Underlying se or injury	C	_ 555						1	
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een sigr hould be							24a. Wa	s an autop	osy 2	4b. Were aut	opsy findings
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The law ate hes t page 2 s								ectio			
certificate h rector, page	05 14/00 0000	referred to medical				***		Yes 21	X NO	1 🗆 Yes	2LJ N0
Physician: this certific ral director.	examiner?	referred to medical	Hospital:	in aller	10 de disease of	Other	of Death (Check only		0 00000	(C/t-)	
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Attending Ph or death. ector: After th by the funeral	1 Natura 2 Accide	1 5 Pending	28a. Date of In (Month, E	Dey Year)	Injury	Work? 1 ☐ Yes 2 ☐ N	lo	-			
Attandli death. ctor: A yy the fu	3 🗆 Suicid	le 6 Could not	be one Blace of I	njury - At home	e, farm, street, fac		28f. Location	(Street on	d Number o	or Rural Route	9 Number,
tal or Attanding P is effer death. al Director: After t ied in by the funers Certification:	4 - Homic	cide		etc. (Specify)			City or T	own, Stete)		
To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by Medical Certifi	29a. Cartifier					red et the time, date and					
n 24 house n 24 house pletely fill edical	(Check on one)	₩ 2 Medical Ex	aminer: On the besis and manner:		and/or Investiga	tion, in my oplnion, death	n occurred at the time	, date and	place, end	due to the ca	iuse(s)
	20h Ciametura	end title of certifier				29c. License number		29d. De	e signed (A	Month, Day, Y	ear)
Me the	290. Signature	orio tillo or bortillor	10								
To the Hospital or Attant within 24 hours ether deat within 24 hours all prector: completely filled in by the Medical Certifical	290. Signature	VILE M	Mell			O.C.M.E		Marci	n 14,	1999	

State Registrar

31. Date filed (Month, Day, Year)

KAR 1 6 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 625AM Georgette Jenkins MARCH 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street and number) Mercy Stella Maris Baltimore Hospice NA If Undar 24 Hrs. 8. Date of Birth Hours | Min. (Month, Day, Year) 5. Social Security Number 2 4 3 - 1 2 - 9 4 1 2 If Under 1 Yaar Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) Deys 1 ☐ M 2 🖺 F 76 Yrs Sept 1922 N. Carolina Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits NA Baltimore Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6624 Hartwait 21224 Street U.S. of America

1 ☐ Yas 2 ☑ No

House Keeping

16e. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired)

13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.)

Specify:

Dolores

19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda)

14. Raca - Amarican Indian, Black, Whita, atc.

16b. Kind of Business/Industry

Offices

18. Mothar's Nama (First, Middla, Maidan Sumama)

White

Unknown

12. Was Dacadant Ever in U,S. Armed Forces?

1 Yas 2 No If Yas, Give Yaar or Datas:

College (1-4or 5+) NA

Funeral Director 2 should be filed within 72 hours after death and Mental Hygiana. Pages 1 and 2

Physician

/Medical

Examiner

10a. Stata

Md.

1 Never Marriad 2 Merried

15. Decedant's Education (Specify only highest grade complated)

3€ Widowed 4 Divorced

Elamantary/Secondery (0-12)

Unknown

17. Fathar's Nama (First, Middla, Last)

19e. tnformant's Name/Ratationship (Type, Print)

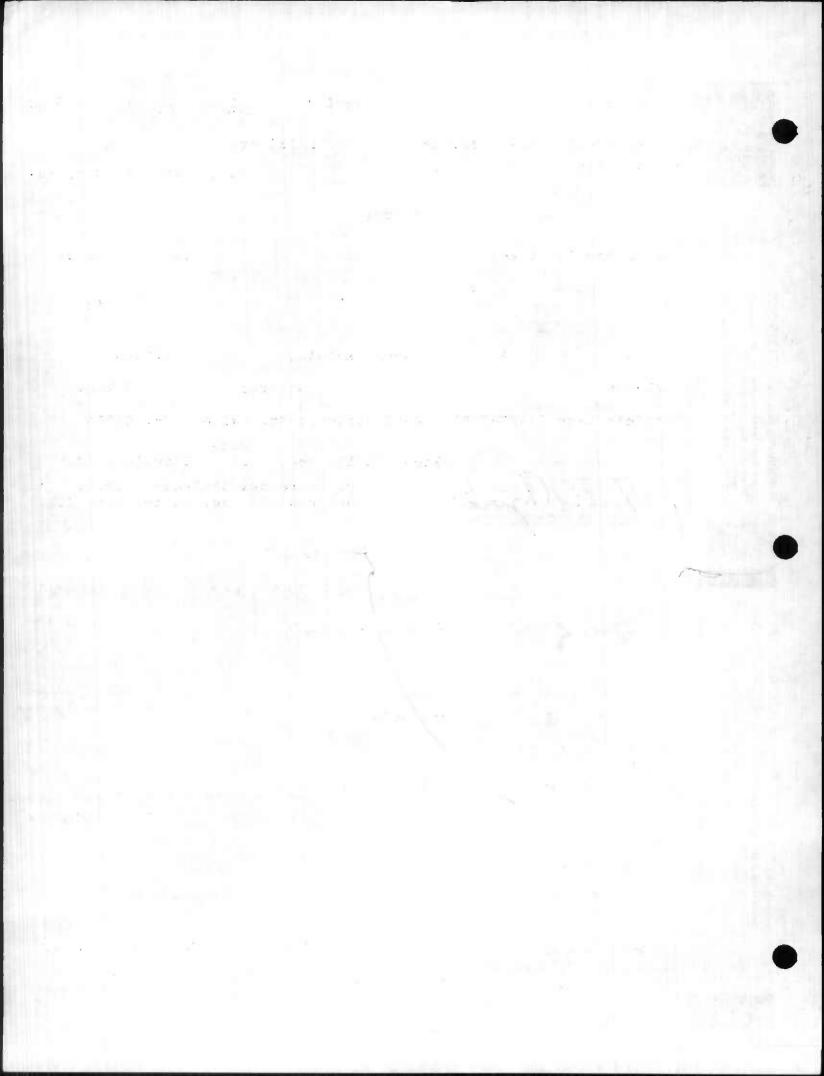
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Funeral

2

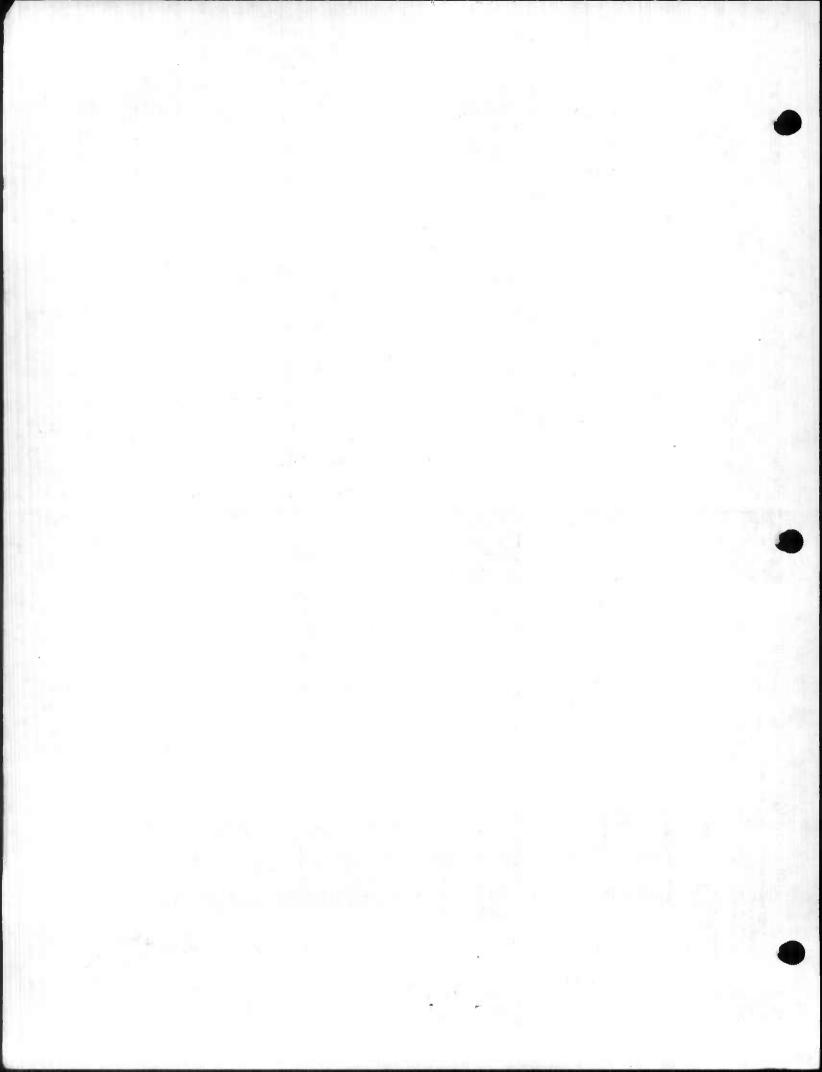
Completed

item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at Department of Health and Mental Hygis Important: if Item 27 is marked other Patricia Lacy (DAUGHTER) 6624 Hartwait St. Balto., Md. 20a. Method of Disposition 20b. Ptace of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stete March any injury or o 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 16 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Timonium, Md. 22. Nama and Address of Fecility
W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224 thet caused the daath. Do not enter the moda of dying, such as cardiac or raspiratory arrest, me on aach tina. Approximate Interval Batween Onset and Death Physician /Medical Immediata Causa (Finat diseasa or condition rasulting in daath) Examiner Dua to (or as e consequence of) Examiner that the death certificate be axecuted attending physician and for usa as tha bunal-trane Sequentially list conditions, if any, taading to immadiata causa. Enter Undarlying Causa (Diseasa or Injury that initiated avents rasulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tha datached signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No ģ 24b. Wara aulopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? paga 2 cartificata has 212No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medicat axaminar? 26. Place of Death (Check only one) STE //A MARIS Be Hospital: Other: 4 Nursing Home 5 Rasidanca 1 Yes 2 No 6 Mothar (Specify) HOSDicE 10 1 Inpatiant 2 ER/Outpatlant 3 DOA Aftar this 28a. Date of tnjury (Month, Day Year) unaral 28d. Describe how Injury occurred 27 Menner of Death 28h Time of 28c. Injury at Work? Certification: Hospital or Attending Natural 5 Panding investigation s aftar daath. 1 TYes 2 No 2 Accident 6 Could not be datarmined 3 ☐ Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of tnjury - At homa, farm, street, factory, offica building, atc. (Specify) 4 | Homicida 24 hours 📬 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha ceuse(s) end mennar as stated. Medical complataly 2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the ceuse(s) and manner stated. (Check only one) within 2 eg. 29b. Signatura and titla of certifian 29c. Licansa number Data signad (Month, Day, Year) D40854 30. Nama and addrass of person who complated cause of deeth (Itam 23a) (Type, Print) BAHIMORE, STP 301 SEBERG DAVID 31. Data filed (Month, Day, Year) 32. Ragistrar's Signetura State Registrar **DHMH 16 Ray 6/95**



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

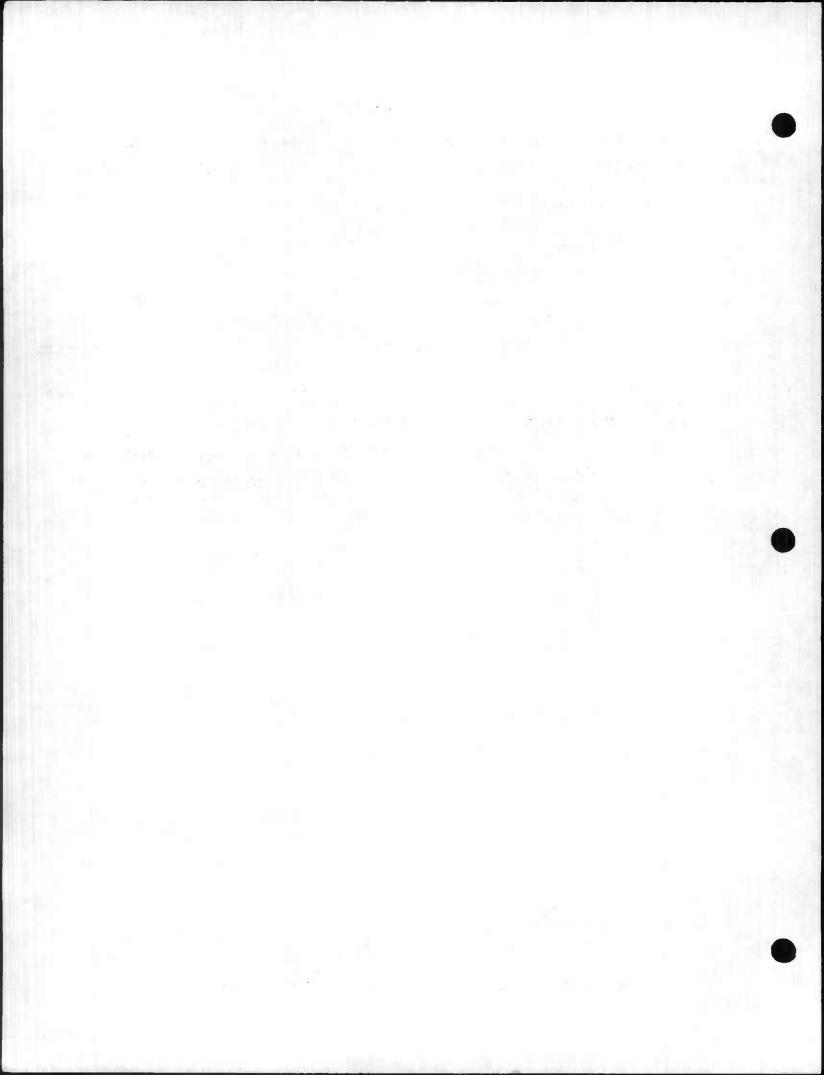
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Physic	ian	Decedent's Name (First, Middle, L.	ast)					2. Dete of Dee Month	oth Dey	Yeer	3. Time of Death
/Med		WILLIAM	JOHNS	ON/				3 -	9-	79	8-12 Pm
Exami	ner	4a. Fecility Neme (If not institution, g.	stitution, give street end number) 4b. City, Tow						4c. County	of Death	
		Mariener Hea	lth of M	- Cl			Baltim	ore	N/	Α	
Funeral		Mariener Hea 5. Social Security Number 6.	Sex 7. A	ge (In yrs. half the	Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, De)			elece (Stete or Foreign
Director		215-22-5357 Usual Residence of Decedant	1 M 2 F	72	Yrs.	Days	Hours Will.		1926		
fand		10e. State 10b. County		10c. City, Tow	n or Location				Δ.	1	0d. Inside City Limits
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the 28s	Funeral Director	Md . N/A	· · · · · · · · · · · · · · · · · · ·	Balt	imore	and a			10g. Citizen of V	****	
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	S		Armed Forces	?	13. Was Decedar	nt of Hi y Cube	spenic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Raci Bled	a - Americ k, White,	an Indian, etc.
0 0	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give X Yeer or Detes:	№	1 ☐ Yes 2	No S	Specify:		Specify	Bla	ick
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Hygi ther mt, p		17. Fether's Neme (First, Middle, Las	t)		Laborer		18. Mother's Neme	e (First, Middle.	Meiden Surnam	(<u>C</u>	
ges 1 and 2 should be filed within 7 to Health and Mental hygiene. If item 27 is marked other than "n or other traumatic event, tre Med	o Be		'					, ,	worrnall!	-/	
d Me	10	Archie Johnso 19e. Informent's Name/Reletionship		406	Mailing Address (Ct	Netti	e John	son_		0.11
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teall and ther		Jeanette Scot	t/Sister	1 2	201 Doro Disposition (Nema y, cremetory or other	che.	ster Av	e, Bal	timore	Mo	. 21207
permit. Peges 1 and Department of Health Important: if item 27 any injury or other tr		20a. Method of Disposition 2 ☐ Cremation 3 [Removel from Stata	cemeter	y, cremetory or other	er pleca	a)	Dete	20c. Location -	City or To	wn, State
Ly in P		4 Donetion 5 ☐ Other (Speci	<i>fy</i>)	Meado	owridge	Mei	m Park	3/15/9	9 Elkr	idge	, Md.
permit. Peges 1 s Department of He Important: if item any injury or othe		21. Signature of Funeral Service Lice	nsee /		22. Name end						
		Wall Make	de Bro	21/2-	Willia	am (C. Brown	n Comm	unity :	Fune	ral Home
		Pert1. Enter the diseese, or con shock, or haart failure. List only	plications thet cause	d the death. Do r	not enter the model	of dvine	North	V Capiret Bar	Ltimor	2, M	
Physician		shock, or haart failure. List only	one ceuse on aach I	ine.		-, -, -, -,	,,	or roop notory and	-		Approximate 217 Intervel Between Onset end Deeth
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	ē				consequence of):		- (1	- 0 -		1
be executed sician end buriel-transit	Examiner		b. Carl	conon		ve	100	Zon /	relogic	la	19
g physician end	xa	Sequentially list conditions, if eny, leeding to Immediate causa. Enter Underlying Cause (Disease or Injury that initiated events		Due to (or es e o	consequenca of):					į	
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the state of	edicai	resulting In death) Lest		Due to (or es e c	onsequenca of):					1	
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the de	/sic	Pert II. Other algnificant conditions	contributing to death b	ut not resulting in	the underlying cau	se give	n In Pert f.	23b. Did to	obacco use con	tribute to	the cause of death?
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v require been sign	ete							24a. Wes e perfor	med?	ave	ere eutopsy findings eileble prior to apletion of cause
hes to	Completed										death?
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sician: The section of	Be	25. Was case refarred to medical axeminer?					26. Place of Deeth	(Check only or	ne)		
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d Die de	er.	4 🗆 Homicide	building, at	c. (Specify)				City or Tow	n, Stete)		
To the Hospital or A within 24 hours after To the Funeral Direction pletely filled in b	edicai C	(Uneck only 2 Medical Exal	ysician: To the best onliner: On the basis of	of my knowledge,	deeth occurred et f	the time	e, dete end piece, e	and due to the c	euse(s) end mei	nner as st	eted.
within 2. To the F	ed	UTIE)	and manner st	stell.							
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Sta	te	31. Dete filed (Month, Dey, Year)	32. Registr	er's Signeture	VU ,	0		MANAGO.	JS TERI	4	4. 2122/
Registr		MAR 1 6 1			41	. 11	,				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ANNA **JACOBSON** MARCH 11, 1999 12:25 AM /Medical 4a Facility Name (tf not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 24 Hrs. 6. Date of Bi JEWISH CONVALESCENT AND NURSING HOME BALTIMORE 6. Date of Birth Month Day, Year) MAY 18 1906 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar 9. Birthplaca (State or Foreign **Funeral** Days 213-44-8778 1 M MXF 92 Months Hours ILLINOIS Director Usual Residence of Decedent 10a. State MD 10c. City, Town or Location RANDALLSTOWN 10b. County BALTIMORE 10d Inside City Limits "natural", or hams 23s or 28a-f show 1 Yes ZXNo Director 10e_Street and Number 5 SHERATON ROAD 10f. Zip Code 21133 10g, Citizen of What Country? U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11 Marital Status Black, White, etc. ☐ Yas 2 No f Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify WHITE à 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) SECRETARY TAX COMMISSION OF MD 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If Item 27 is marked or Pages 1 and 2 should be MAURICE COPPEL **EVA** LEVIN 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MIMI BILLER/ DAUGHTER SHERATON ROAD RANDALLSTOWN, MD. 21133 20b. Place of Disposition (Name of 20a. Method of Disposition

↑ Burial 2 □ Cremation 3 □ Remograf from State Date 20c. Location - City or Town, State B'NAI ISRAEL CONG. CEMETERY 3/14/99 BALTIMORE MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, 21208 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final RIMENS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last and Due to (or as a consequenca of): attending physician for use as the buria Box 68760 Physician/Medical the Due to (or as a consequenca of): P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No-1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat meral Director: 6 Could not be 3 ☐ Suicide Location (Street end Number or Rurat Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. Medical 29a. Certifier 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 300 COURT ROAD, 40000 OLD ROBERT KROOPNICK, M.D. BALTIMORE, MD 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State MAR 16 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Day LARRY K. KEGLEY 13, March 1999 2:30 am 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Towson Gilchrist Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. last birthday) Months 10 M 2 F Deys Hours 44 Yrs. 218-62-4897 July 25, 1954 Maryland Usuel Residence of Decedent 10d. Inside City Limits 10e State 10b. County 10c. City. Town or Location 1 MYes 2 □ No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21224 U.S.A. 7859 East Baltimore Street 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 📉 No Specify: White Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Metro Express Balto.Inc 12th Grade Driver 18 Mother's Name (First Middle Maiden Surneme) 17. Fether's Name (First, Middle, Last) Marethia Mae Perdue Frederick Acton Kegley 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 7859 East Baltimore Street Baltimore, MD Marethia Mae Kegley / Mother 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 3/16/99 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service License Connelly Funeral Home Of Essex 300 Mace Ave. Baltimore, Maryland omplications that caused the dayin. Do not enter the mode of dying, such as cerdiec or respiretory errest, any one cause on each line. Approximete Intervel Between Onset end Deeth Pert1. Enter the diseese, or shock, or heart feilure. List of Immediate Ceuse (Finel disease or condition resulting in deeth) wer Due to (or es e consequence of): hosi 5 01 Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of) Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Injury or

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

P

Completed

7 is marked other than "natural", or itema 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at

filed within 72 hours after death v Hygiene. ther than "natural", or items 23

permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 is marked of

Baltimore, Maryland 21215-0020

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3

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Examiner

Physician/Medical

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Certification:

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25. Wes cese referred to medical examiner?

1 Yes 2 No

27. Menner of Deeth

1 Naturel

3 Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only

29b. Signature and

physician signed by certificate has this After

Attending 8

LArry Kegley

State Registrar

Hospitel: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of 5 Pending Investigation

28c. Injury et Work? 1 Yes 2 No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSpice 28d. Describe how injury occurred

26. Piece of Death (Check only one)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 29c. License number

MArch 13, 1999

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)
W.A. R. Ley GBMC 6701 N. Charles St. Balto. md 21204 6701

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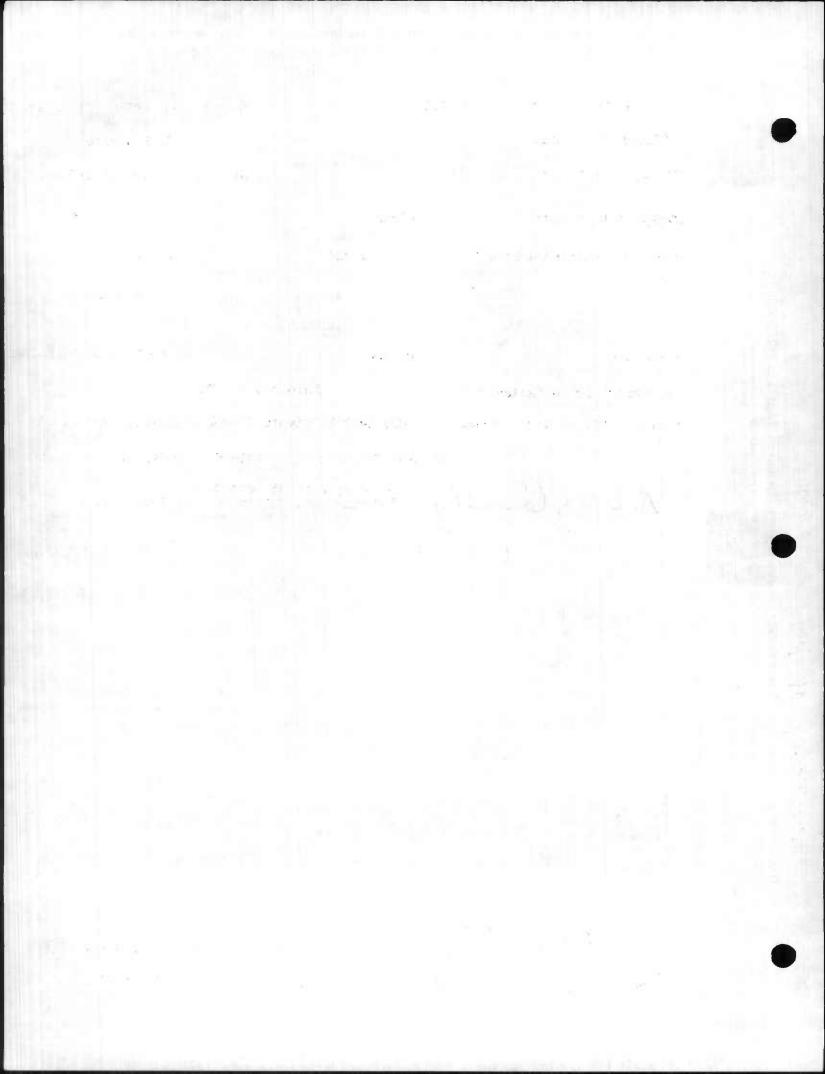
32. Registrer's Signature

6 Could not be determined

death.

Director:

within 24 hours a To the Funeral D Hospital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 10:45 am Charlotte S. Kaplan March. 4a. Facility Nama (If not institution, give straet end number) 4b. City. Town, or Location of Death 4c. County of Deeth Catons ville 15 u If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year) Sept. 18, 1907 Charlestown Care Center Bultimort If Undar 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (Stete or Foreign Months Deys 1□M 2₩F 91 Baltimore, MD Yrs. 220-14-2268 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Queen Anne Chester XX Yas 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States 21619 1512 Calvert Road 12. Wes Decedent Ever In U,S. Armed Forcas? Race - Amarican Indien, Bleck, White, atc. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 1 ☐ Yes 2 ☐ No If Yes, Give X Yaar or Detes: 1 Navar Married 2 Marriad white 1 ☐ Yas 2 No Specify: Specify. 3X Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Clerk IRS 18. Mother's Neme (First, Middle, Melden Surneme) 17. Fether's Neme (First, Middle, Last) Karl Bock Dora Joergeson 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1512 Calvert Road, Chester, MD 21619 Delores C. O'Brien/Daughter 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stata 3/11/99 Baltimore, MD 5 ☐ Other (Specify) Loudon Park Cemetery 4 Donetion 21. Signatura of Furerel Service Ligensea 22. Neme end Addrass of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 21229 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Causa (Final disaese or condition resulting in deeth) Cerebro Vascular Accident Fibrillation Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 200 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to complation of cause of daeth? 24a. Was an eutopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Megner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 2 Neturel

Physician /Medical Examiner

Physician

/Medicai

Examiner

MD

Director

Funeral

by

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, any injury or other traumatic event, any injury or other traumatic event, are injury or other traumatic.

Baltimore, Maryland 21215-0020

Kaplan

Charlotte

Name:

Box 68760

Division of Vital Records, P.O.

Examiner Physician/Medical by Completed

attending physician and for use as the bunal-transit signed by the atte Hospital or Attanding Physician: After this 24 hours after death. Funerel Director: Af

State Registrar

Certification: To

Medicai

2 Accident

4 Homicide

29b. Signetura and title of cartifier

3 Suicide

29a. Certifier

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) Andres Suluzar 31. Data filed (Month, Day, Year) MAR 1 6 1999

6 Could not be determined

82. Registrer's Signeture

Maiden choice lane, catousville, MD, 21228

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and menner steted.

29c. Licansa number

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Data signed (Month, Day, Yaar)

DHMH 16 Rev 6/95

To the I within 2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year 9:40 a.m. Richard William Kaminski March 13, 1999 4h. City. Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Genesis Eldercare - Perring Parkway Center Parkville Baltimore Co. 7. Age (In yrs. last birthday) If Under 1 Yeer 6. Sex 1 Ø M 2 □ F If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) April 10, 1938 5. Sociel Security Number Birthplace (State or Foreign Country) Months Deys Yrs 60 Maryland 219-26-2961 Usuet Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Maryland N/A Baltimore City 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 2818 Chesley Avenue 21234 United States 14. Rece - American Indien Black, White, etc. . Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 1 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 2 yrs. Salesman Gold Leafing Jewelry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John Joseph Kaminski Frieda Seaderer 19a. tnforment's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine D. Kaminski / Wife 2818 Chesley Avenue Baltimore, MD 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐XCremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corporation 3/18/99 Towson, Maryland 22. Name and Address of Fecility 5305 Harford Road 21214 LEONARD J. RUCK, INC. Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failuril. List only one cause on each line. Approximate Intervel Between Onset end Deetl Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

physician and s the burial-transit

signed by

peen

certificate

Be

Certification:

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completaly filled in by the funeral director,

Box 68760

Records, P.O.

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours after

Hygiena.

permit. Pages 1 and 2 should be flied w. Department of Health and Mental Hygien. Important: if item 27 is marked other tha any injury or other traumatic event, jites page.

Baltimore, Maryland 21215-0020

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Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical þ Completed

Part tf. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t.

25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 2 ☐ Accident 5 Pending 1 Yes 2 No investigetion

6 ☐ Could not ba 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Phyafclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation in any applications in any applications. 29a. Certifier (Check only

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29b. Signeture and title of certifie 29c. License number Zlad Missu

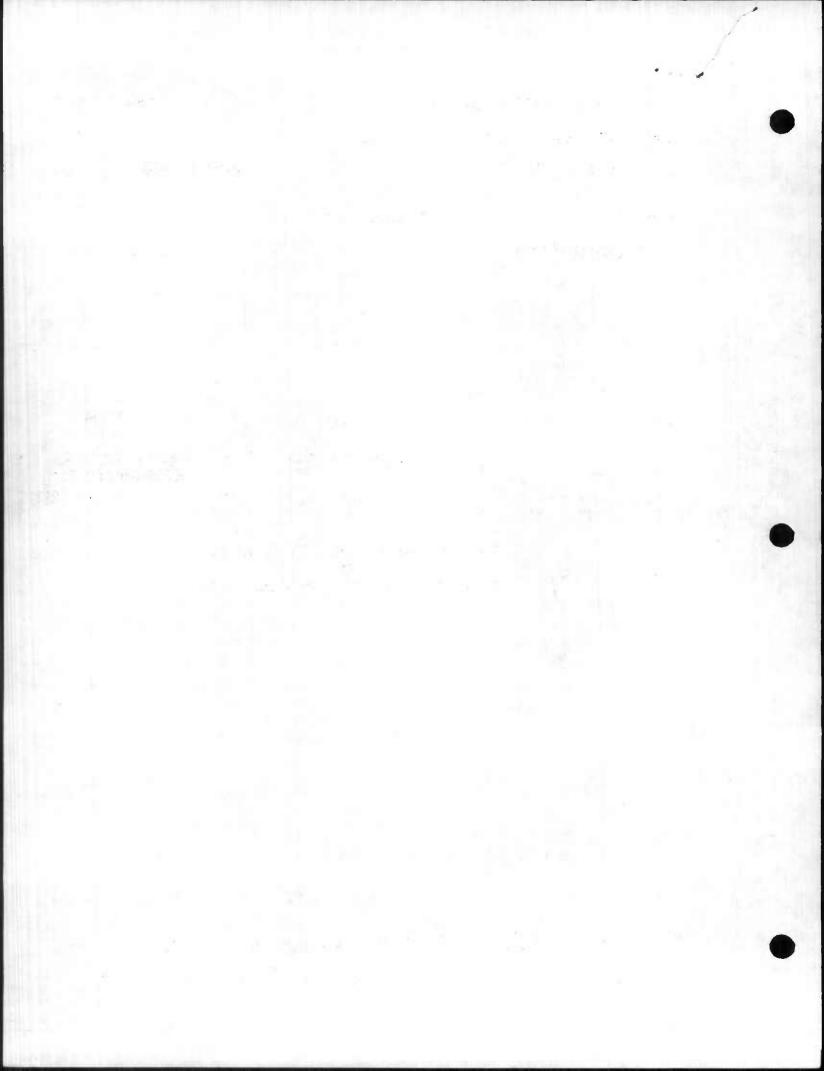
30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print)

3007 6 No Hem Parkway, Bulking, ms CEN MYD, 2100

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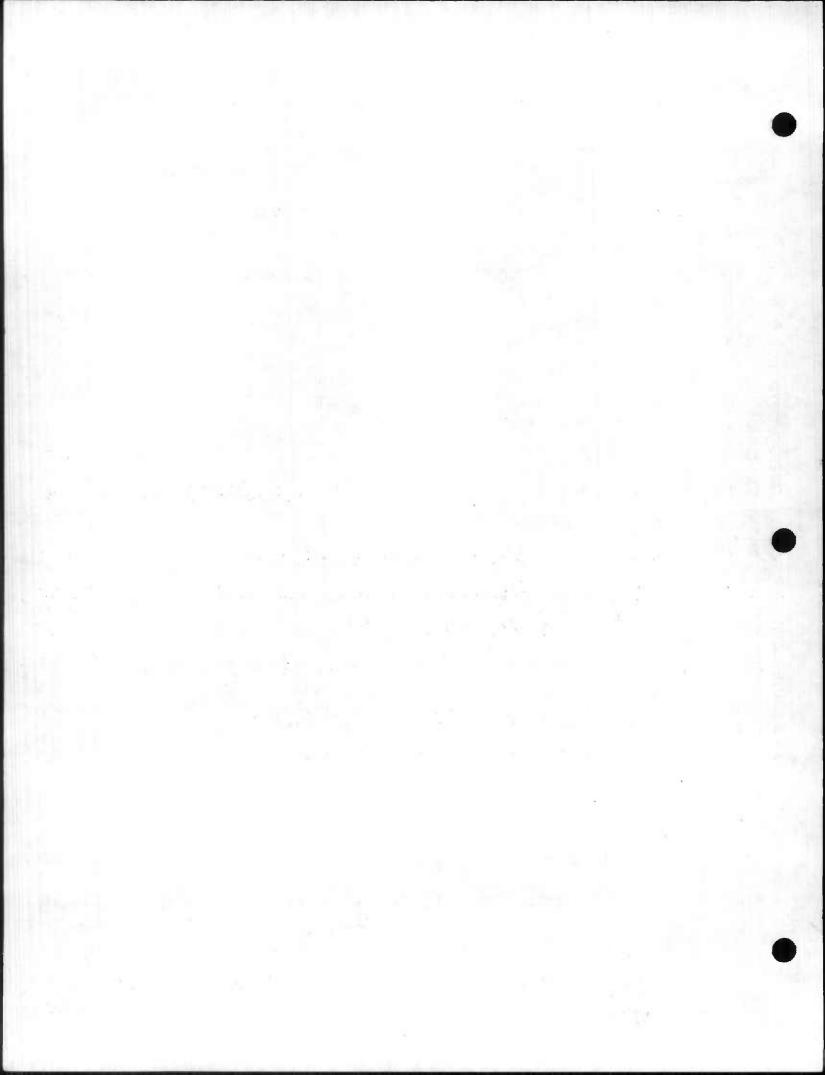
31. Dete filed (Month, Day, Year) State Registrar

32. Registrer's Signeture park



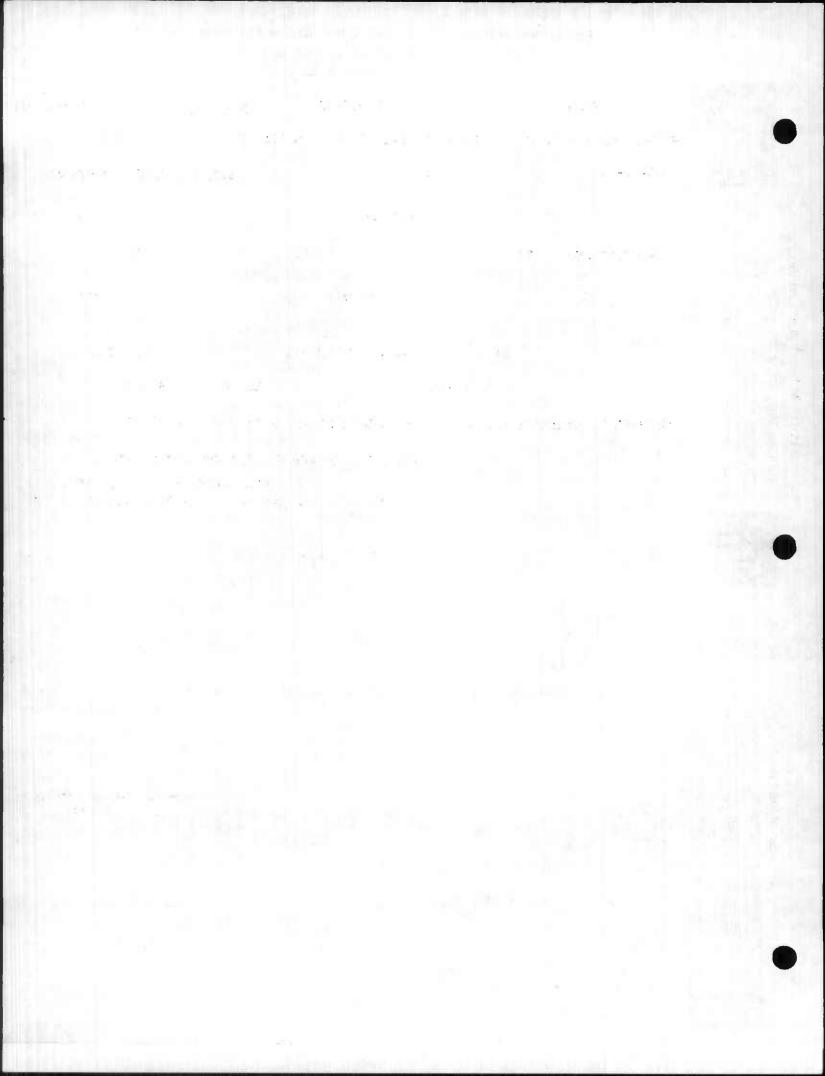
		State of Mai		ertificate of			eg. No.	1207
Physician	Decedent's Name (First, Middle, La: Helen	D.		Kennedy		2. Date of Deat Month	Day Year	3. Time of Death
/Medical Examiner	4a Facility Name (If not institution, give				4b. City, Town, or L	March ocation of Death	8, 1999 4c. County of Death	8:48 PM
	Church Home and			Williados 4 Vocas	Baltimo		n/a	
Funeral Director	5. Social Sacurity Number 6. S 223 30 8866 1 Usual Rasidenca of Decedent	OM 257F	70 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Deta of Birth (Month, Day, NOV • 27	Year) 9. Birthp County	lece (Stata or Foreign try) jinia
with the Maryland ta or 28a-f show the notified at	10a. State 10b. County		Oc. City, Town or L		Baltimore	9	1	0d. Inside City Limits 1 XYes 2 □ No
£ 23 £	10e. Street and Number 705 S. Bethel St	•		10f. Zip Code	1231	1	Og. Citizen of What Coun United Stat	
ors of the by	3 Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Dates:	ar in U,S. 13.	Was Decedent of H If Yas, specify Cub 1 ☐ Yas 2 N No	dispanic Origin? (Sp en, Maxican, Puarto Specify:	ecify Yas or No- Rican, etc.)	14. Race - Amaric Black, Whita, Specify:	
ind 21215-0 be filed within 72 ho tal hydiene. I other than "naturi avent, the little	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usual Occup	pation during most of work d)	ring	16b. Kind of Business/Ind	lustry
212 d within giene.	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	Homemak			Do	omestic
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C - N L	19a. Informent's Name/Relationship (1 Stella Knighton /		796	1 E. Shor	e Rd., Pa		City or Town, State, Zip MD 21122	Code)
Baltimore, emit. Pages 1 ar separtment of Heam portant: If item in Injury or other ince.	20a. Method of Disposition 1 Burial 2 December 3 4 Donation 5 Other (Specify			osition (Neme of emetory or other plea unt Crema		Data :	20c. Location - City or To Baltin	more, MD
Baltimo	21. Signature of Funeral Service Licental	varie		2. Nama and Addre CAFA Step 8717 Gree	hen D. Lo	ohrmann I	P.A. Baltimore, N	D 21286
	23a. Part1. Enter the disease, or companies, or haert failure. List only	plications that caused the	a death. Do not en	iter tha moda of dyin	ng, such as cardiac	or raspiratory arm	est,	Approximata Interval Batween Onset and Death
/ Physician /Medical	Immediata Ceusa (Final disaasa or condition	R.00.	on Form	. Ca	201000	2		for a a c
Examiner	rasulting in death)	River	ua to (or as a conse	Quence of):	1.11011	(10	10	davo
58760, icate be executed physician and sthe burial-transit	Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events	A	ue to (or as a conse	quence of):	week.			1000
	that initiated events resulting in death) Last	Bulat	is to (or as a conse	quence of):	000	2/000	0 0	odann
death certification of for use a siclar/Me		d. B ()	eval	Mell	VUX 6	of the	sean!	ray
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cord require been si should	Anemia	Elo	tvol	, to u	insance	24a. Was a perform	ned? av	ara autopsy findings ailable prior to mpletion of cause death?
f Vitai Relevatelen: The lav	/			7		10 Ye	11	Yas 2 No
Of Vita Physician: this certific ral director,	25. Was casa referred to medicel examiner?	Hospital:	2 ☐ ER/Outpatie	ent 3 DOA Oth	26. Place of Deal		ence 6 Other (Specific	v)
ion of	27. Manner of Death 1 Natural 5 Pending 2 Accident invastigation	28a. Data of Injury (Month, Day)	28b. Tima o	of 28c. Injur			ow injury occurred	
Division of To the Hospital or Atlanding Physician 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director Medical Certification: To Medical Certification: To	3 Suicide 6 Could not be determined	28e. Plece of Injury building, atc.	- At homa, farm, si (Specify)	reet, factory, offica		28f. Location (St City or Town	reet end Number or Rura n, State)	l Routa Number,
n 24 hound n 24 hound he Funer pletely fill edical	29a. Certifier 1 Certifying Phyone) 1 Medical Exam	ysician: To the best of r liner: On the besis of en and mannar state	camination and/or in	th occurred at the tire transfer in the tire of the transfer in the transfer i	me, date and place, prinion, death occur	end due to the cared et the time, da	ause(s) and mannar as st ate end place, and due to	ated. tha cause(s)
To the comp	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Data signed (Month,	Day, Year)
7/10	30. Name and address of person who	Umpleted causa of that	th (Item 23a) (Type	Print)	720	2	0/12/	9
State	31. Data filed (Month, Day, Year)	32. Hegistrar's	0100	Hele	na A	10 80	Donor	2 Md.
Registrar	MAR 1 6 1999	Beave	B.	Sparks				12)
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ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

				Certifica	ate of l	Death		Reg. No.	00200					
Dhysisian	1. Decedent's Name (First, Middle, Las	t)					2. Dete of De	eath Day	Year 3. Time of Death					
Physician / / / / / / / / / / / / / / / / / / /	HYMAN			KAM	INKOW		March	1 10,1	999 7,40A					
Examiner	4a Facility Name (If not institution, give STELLA MARIS HOSE		Y MED	ICAL CE		b. City, Town, or BALTIN		h 4c. County	of Death N/A					
Funeral Director	5. Social Security Number 6. Social Security Number 220–20–6745	9x 7. Age (In	yrs. last birt 91	Month	ler 1 Year s Days	If Under 24 Hrs Hours Min	. (Month, De	th ly, Year) 16, 1907	9. Birthplace (State or Foreig Country) MARYLAND					
>	Usual Residence of Decedent 10a. Stete 10b. County	10	c. City. Towr	or Location					10d. inside City Limit					
show in	MD N/A			LTIMORE					1. Ves 2 N					
or 28e-f s be received	10e. Street end Number	3	באנו		Zip Code			10g. Citizen of What Country?						
23a or unitber	17-D CROSSKEYS F	ROAD			21	.210		U	J.S.A.					
"naturel", or items 23s or 28s4 show edical Examiner must be notified at ileted by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:	in U,S.		Was Decedent of Hispenic Origin? (Spet Yes, specify Cuban, Mexican, Puerto		Specify Yes or No to Rican, etc.)	Specify	ck, White, etc.					
ygiene. Ar than "nature t, the Medical Completed	15. Decedent's Ed	ucation de completed)	16a.	Decedent's Us	sual Occup	ation during most of wo	rking	16b. Kind of Business/Industry						
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the the the the the the the the the the		5+		SCHOOL	PRINC				CATION					
d out	17. Fether's Neme (First, Middle, Last)	*** ******	TZOLI					(First, Middle, Malden Surname)						
Department of Heelth and Mantal Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, tra Manones. To Be Compli	ELI	KAMIN					STHER	KORMAN						
	19a. Informent's Name/Relationship (7								State, Zip Code)					
Heelth of the other tra	MICHAEL E. KAMIN			B REGEN Disposition (N		URT, BAI								
Department of He important: If iten any injury or oth once.	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donetion 5 Other (Specify	Removal from State	a) SATION	3/11/99		City or Town, State MILLS, MD								
Departimontal any injury 21. Signature of Funeral Service Licen	500				ss of Facility SCERSTOWN			ROS., INC. LE, MD 21208						
ysician Medical aminer	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Ceuse (Final disease or condition resulting in death)	8		consequence o	be a		c or respiratory a	mest,	Approximate Interval Between Onset and Death					
g physician and as the buriel-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause, Disease or Injury that initiated events resulting in death) Last	c		consequence of										
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ed by detec							1 🗆	Yes 20 No	3 Probably 4 Unkno					
page 2 should be deteched for use page 2 should be deteched for use Completed by Physician/A							24a. Was perf	an autopsy ormed?	24b. Were eutopsy findings available prior to completion of cause of death?					
certificate hes rector, page 2 Be Comp							10	Yes 2 No	1 ☐ Yes 2 ☐ No					
octor, I	25. Was case referred to medical					26. Place of De	ath (Check only	one tella	MARIS AFMERS					
neral direc	examiner? 1 Ves 2 No 27. Menner of Death 1 Natural 5 Pending	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yee	2 ER/Ou 28b. T		DOA Oth	4 LI Nursing I	Home 5 ☐ Res 28d. Describe	dence 6 Oth	er (Specify) has plu					
ctor: After by the funer fication:	2 Accident investigation 3 Suicide 6 Could not be	28e. Placa of Injury -	At home, fa	rm, street, facto		Yes 2□No			per or Rurel Route Number,					
rer death. Irector: A n by the fi														
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no 24 hours after death. Ne Funeral Director: A pletely filled in by the fi edical Certificati	29a. Certifying Phy	rsician: To the best of my liner: On the basis of exa and manner stated.	y knowledge mination and	d/or Investigation	on, In my o	plnion, death occ	urred at the time,	date and placa,	and due to the cause(s)					
	29a. Certifier (Check only 2 Medical Exam	Iner: On the basis of exa	y knowledge mination and	d/or Investigation	on, In my o	plnion, death occ	urred at the time.		and due to the cause(s) d (Month, Day, Year)					
within 24 hours after Geath. To the Funeral Director: A completely filled in by the filled	29a. Certifier (Check only one) 29b. Signature and title of certifier	Iner: On the basis of exa	mination and	d/or Investigation	on, In my o	plnion, death occ	urred at the time,		and due to the cause(s)					
within 24 hours arrar death. To the Funeral Director: A completely filled in by the filled	29a. Certifier (Check only one) Certifying Phyone	Iner: On the basis of exa	mination and	d/or Investigation	on, In my o	plnion, death occ	urred at the time,		and due to the cause(s)					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** . 1999 VERNON W. KRAUS MARCH 9, 7:45 PM /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3601 CLARKS LANE, APT. # 410 BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Deys 1QM 2□ F Montha Hours Director 84 277-18-9167 MAY 13, 1914 ILLINOIS Usuel Rasidence of Decede 10a. Stete 10d. Inside City Limits 10b. County 10c. City. Town or Location r 28a-f show notified at MD N/A BALTIMORE 1 TYes 2 □ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8 must be 3601 CLARKS LANE, APT.#410 21215 U.S.A. "natural", or flams 23a Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?
MXYes 2 No W.W.II
IYês, Give
Yeer or Detes: NAVY Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent'a Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT SUPPLIES Hygiene. MERCHANT 12 & FOUIPMENT Department of Health and Mental Hyginteportant: If Ison 27 is marked other any injury or other traumatic event. I 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumeme) Be Pages 1 and 2 should be next of Health and Mental EMIL KRAUS **ESTHER** NAGEL 2 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Raletionship (Type, Print) 3601 CLARKS LANE, APT.#410, BALTIMORE,MD 21215 BEATRICE KRAUS / WIFE 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from Stete 3/11/99 ARLINGTON-CHIZUK AMUNO BALTIMORE, MD 4 Donetion 5 Other (Specify) 21. Signature of Juneral Service License 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximeta Interval Batween Onset end Death **Physician** tmmediete Cause (Finel disease or condition resulting in daeth) /Medical Pulmonan Edens week Examiner Due to (or es a consequance of): Examiner 4021211C Concar 400 Lung the burial-transit be executed Sequentially list conditiona, if any, laeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and Due to (or es a consequence ot)£ Box 68760. physician Physician/Medical Due to (or as a consequence of): 980 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 PYee 2 No 3 Probably 4 Unknown disease, anomia Records, p 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed Sevene chronic constipation Cerebransalor disease 1 Yea 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical axaminer? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1□ Yes 2☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral 27. Manner et Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. tnjury et Work? 1 - Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date end plece, and due to the cause(s) and mannar as stated edicai 29a. Certifie 2 Medical Examiner: On the basia of examinetion end/or investigetion, in my opinion, daeth occurred at the time, dete and place, end due to the cause(s) and menner stated. (Check only one) 29b, Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) ATTENDING PHYSICIAN 3/10/99 04037 30. Name and addrasa of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Dr. Harry Kaplan

MAR 16

31. Date filed (Month, Day, Year)

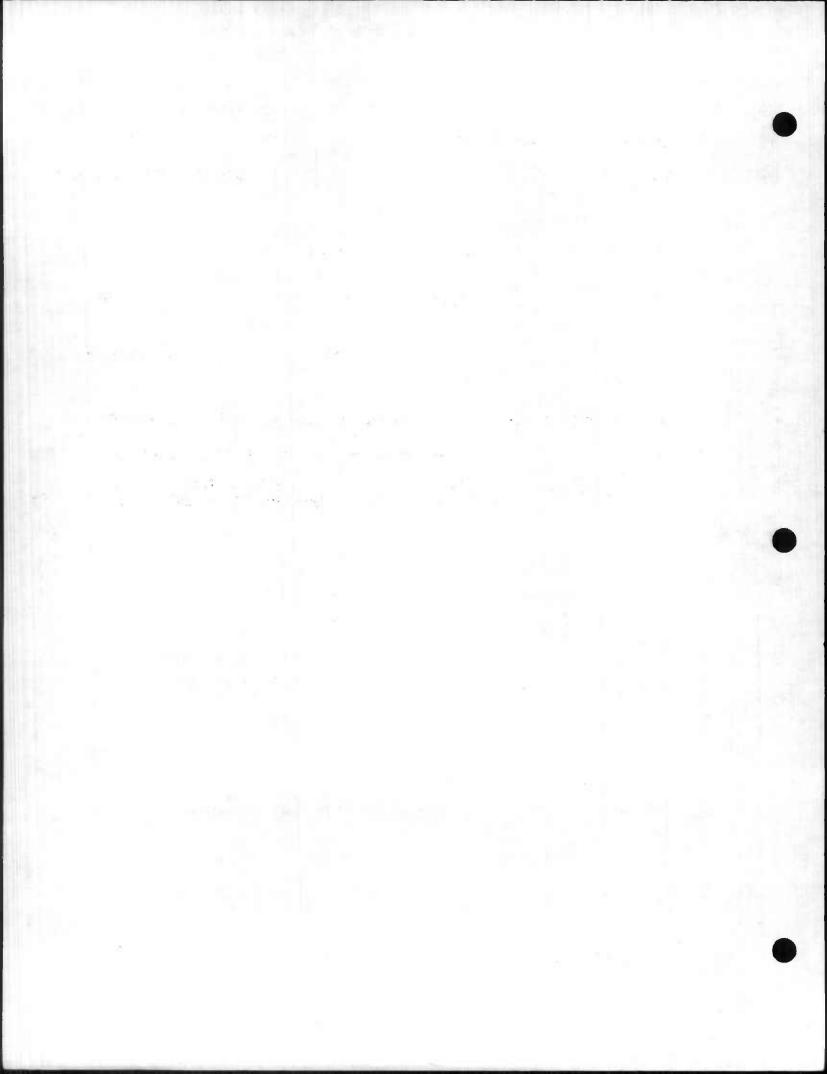
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32. Registrar's Signeture

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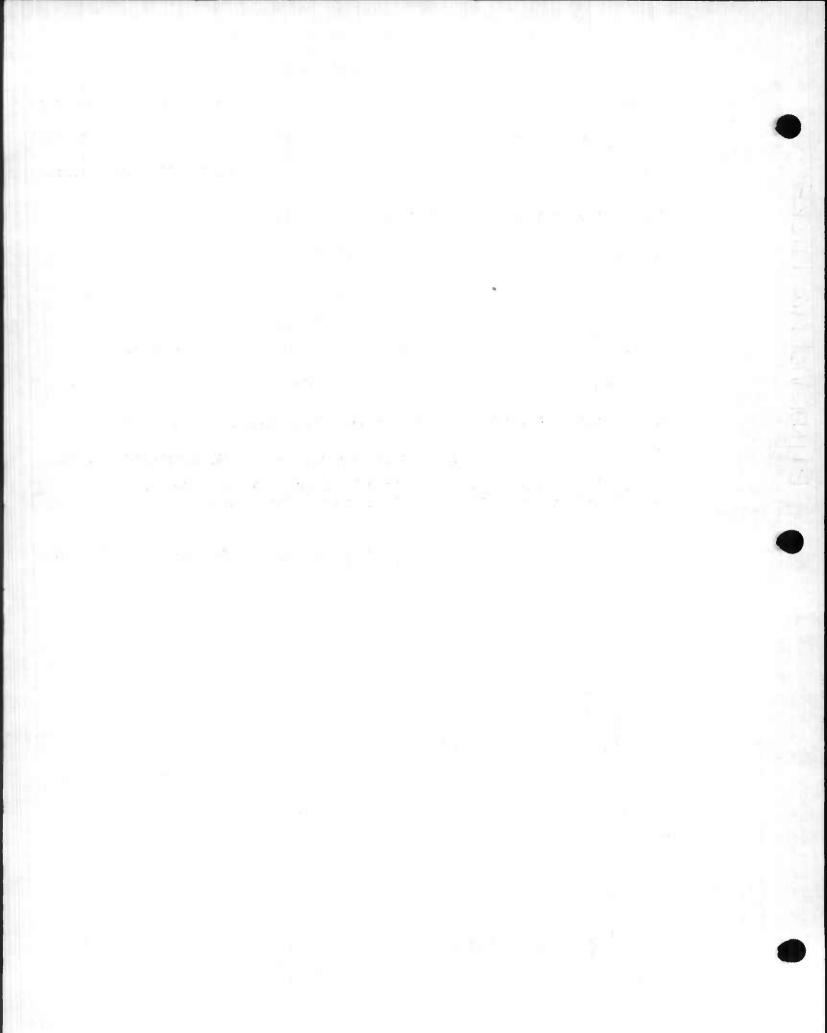
10

20 Crosswads brie aungs Mills, MD 21117



State of Maryland / Department of Health and Mental Hygiene

		1		C	ertificate of	Death		eg. No.	0	8210
Physic	ian	Decedent's Name (First, Middle, Las					Dete of Deet Month	th Day	Year	3. Time of Death
/Medi		ELINOR V.	LUCKE				MARCH	12 ^{Da} 1999)	10:15 AM
Exami	ner	4a. Facility Neme (If not Institution, give	street end number)			4b. City, Town, or Lo	cation of Deeth	4c. County		
		FUTURE CARE OF '	THE CHESAPEA	KE		ARNOLD		ANNE	ARU	NDEL CO.
Funerai Director		213-10-0270	9.1.7	72 Yrs.	y) If Under 1 Year Months Days		8. Date of Birth (Month, Dey Aug. 2	7 1926 I	9. Birthp Cour Penns	plece (Stete or Foreign otry) Sylvania
2 .	1	Usuel Residence of Decedent 10a. State 10b. County	100	Oh. Talla is	Labella					
anylan show adust	<u>_</u>		indel Co.	City, Town or	idena				1	Od. Inside City Limits
S S S S S S S S S S S S S S S S S S S	Sct		nider co.	rasa						1 ☐ Yes ax No
oth with the Maryland 23s or 26s-f show set be notified at	rai Director	1330 Edna Road			10f. Zip Code 211	22	1	0g. Cltizen of V	Whet Cour USA	itry?
5-0020 72 hours absir des natural, or herrs dicel Examiner m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorcad	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give X Year or Dates:	10,S. 13	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 1 No	Hispanic Origin? (Spe ben, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ ck, White, : whi	
	Completed	15. Decedent's Ed (Specify only highest gree		16a. Dec	cedent's Usuel Occu	ipetion a during most of worki	na	16b. Kind of Bu	usiness/Ind	dustry
vithin one. than	npie	Elementery/Secondery (0-12)	College (1-4or 5+)			during most of workingd)	9			
2 D D 2	So	6	0	Hou	sewife			Home (Owner	
BUG Bugger Bugge	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Neme	(First, Middle, I	Meiden Surnem	-/	1
rylan could be Marked o	2	Wesley Remko				Eva			ur	nknown
Maryland d 2 should be file if and Montai Hy 7 is marked othe traumatic event		19a. Informent's Neme/Reletionship (7		19b. Me	iling Address (Stree	et and Number or Rura	il Route Number	City or Town,	Stete, Zip	Code)
0 2 24 4		Anna E. Young	(Daughter)	78	14 Bertha	Road, Pas	adena,	Md. 211	22	
Baltimore, semit. Peges 1 at Sepatiment of Hea montants If Nem. iny Injury or other ince.		20a. Method of Disposition		. Plece of Dis	position (Name of remetory or other ple	ece)	Dete	20c. Location -	City or To	wn, State
Pages Sent of int; if its	10.00	1 □ Burlal 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify	Hemovel from State		Hill Cemet		/15/99 I	Brookly	n Pai	ck. Md.
Baltim omit. Pa Departmen mportsmt; iny injury ince.		21. Signature of Fungral Service Licens			22. Name end Addr	ess of Fecility				,
m same			Kevin Ecker		McCully-F	Polyniak F				
Name and Address of the Owner, where		23a Part 1 Formethe disease or comp	lications that caused the d	eeth Do not e	3204 Mour	ntain Road	, Pasade	ena, Md	. 21	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.	both. Do not e	sister the mode of dy	ing, such as cardiac d	i respiretory erri	551,		Approximete Intervel Between Onset end Deeth
Physician /Medicai		Immediate Cause (Final		1.	Λ		Λ			t.
Examiner		disease or condition resulting in death)	θ	Hout	- Myo	condid	more	tion		word
100000	-		Due to	o (or as e cons	sequence of): (
po ti	ine		b							
and -tran	Examiner	Sequentially list conditions,	Due to	(or as a cons	equenca of):					
50, De ey		Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury Ihat initiated events	0							
68760, filcete be executed g physician and as the burial-transit	edicai	Ihat initiated events resulting in deeth) Last	Due to	(or as e cons	equence of):					
K 6	Me									
Box wath cert attendin for use	an		d							
o des	sic	Part II. Other eignificent conditions co	ntributing to deeth but not a	esulting in the	underlying cause gi	iven in Part I.	23b. Dld to	becco uee co	ntribute to	the cause of death?
IS, P.O. BOX es that the death cer igned by the attendir	Physician/M	Venter Tour					1 🗆 Y	es 2 No	3 Prof	bably 4 🖫 Unknown
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cord v require been si		00 1 +	es Melli	11			24a. Wes e	n eutopsy	24b. W	ere eutopsy findings
w requ	Completed	010621	es view	tus			penon	neur	co	elleble prior to mpletion of cause death?
Recamber law	Ē						404	o (Chai		-1
in: The ficate or, pe		OF Man are and an advantage of		. 7 -			1 □ Ye		11	Yes 2 No
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the bunal-transit	Be C	25. Was case referred to medical examiner?	Hospital:		O:	26. Place of Deeth				
Phys this	. To	1 ☐ Yes 2 No 27. Menner of Deeth	1 □ Inpatient 2		IENT 3LI DON	4 Knursing Hor				y)
ing ling	Certification:	1 Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	lnjury	Wo		28d. Describe ho	ow injury occurr	ed	
Sic Seath Seath tor:	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No				
or At fler fler firec in by	E	4 Homicide determined	28e. Pleca of Injury - Albuilding, etc. (Spe	t home, ferm, : cify)	street, factory, office	1 2	281. Location (St City or Town	reet and Numb n, Stete)	er or Rura	I Route Number,
Tai Pai	ပိ									
Division of Vital Rewith a Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	elcian: To the best of my k ner: On the basis of exem- end manner stated.	nowledge, de netion end/or	eth occurred et the ti Investigetion, in my	ime, date end plece, e oplnion, deeth occurre	end due to the ce ed et the time, d	euse(s) end me ete end place, e	enner es si end due to	eted. the ceuse(s)
Withi Com	Σ	29b. Signature end title of certifier			29c. Licen	se number	2	9d. Dete signe	d (Month,	Dey, Year)
		116)11	Our MA	-	T	-110521	i	March	. 12.	1998
1		30. Name and address of person who ca	ompleted cause of death (le	rem 23a) /Tun	e Print)	1 11/11/2			7	20.7
4		TA A A	Minister pause of death (II	om zoer (Typ	2>1	Wilken	Aver no	NWL ST	NCE	205
Sta	10	31. Dete filed (Month, Day, Year)	32. Registrar's Sig	neture	1300	timore,	~ / LD .	4120		
Regist				ر مستنده	J. hos					
1,03,51		MAR 1 6	1999		- 13					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Month LOWGYU NOVEILA :354 + FDNCES Mar /Medical 4a. Fecility Nema (If not Institution, giva street and number) 4h City Town or Location of Deeth 4c. County of Deeth **Examiner** Atonsville BALTIMORE Manifer VEalth 5. Social Security Number If Undar 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 M F 59 Yrs. Director 64 250 Usuel Residence of Decedent show 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits BALHMOR 1 Vas 2 □ No Director Marylors 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 4738 U512 Wake items 23s 21216 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No by 3 ☐ Widowed 4 ☐ Divorced Specify. Black Completed 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than State of Mary / Pas Elementary/Secondary (0-12) College (1-4or 5+) Arule are Probotion Officer YEMES 17. Fether's Nema (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If item 27 Is merked otha any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumeme) Be /NILBERT 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4738 Walsefield PURO 11USBARD Both work, Md 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Data WOODCHUR, Hary/mus Burial 2 Cremation 3 Removel from State NOOD CAN CEMERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHATMAN - HARRIS KINETHORE 21. Signeture of Funerel Service Licensy BATTOLOUR, LEAVISION 21211 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Betw **Physician** /Medical Immediate Ceuse (Finel Uterino Cancer diseese or condition resulting to deeth) Examiner cancer sician and buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Box 68760, Physician/Medical Due to (or as a consequance of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ Be Completed 24a. Was an eutopsy performed? 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 2 1 No this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical exeminer? 26. Plece of Beath (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Inpatiant 2 | ER/Outpetient 3 | DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Maturel 5 Pending Investigation death. 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Streat end Number or Rurel Routa Number, City or Town, Stete) Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral C Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrad at the time, dete end place, and due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stelled. ş 29c. Licansa number 29d. Date signed (Month, Dey, Yeer) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) , DO N. Rolling Catonsville Si Lee M.D.

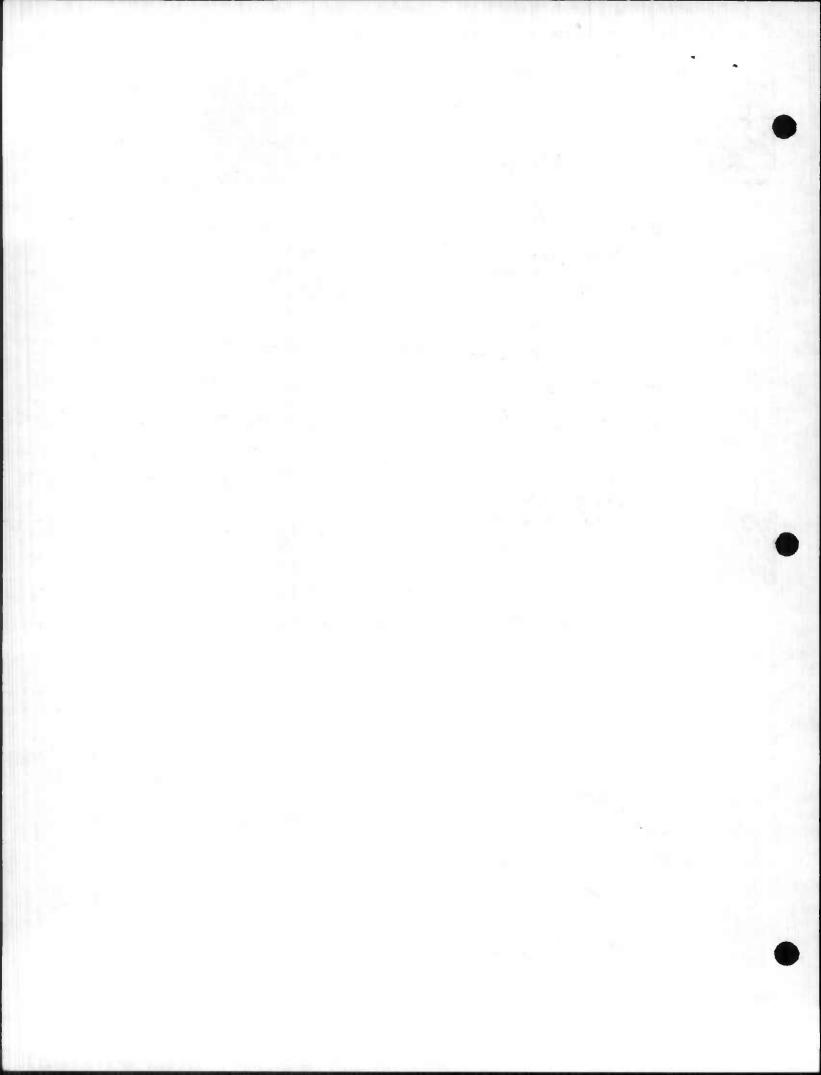
32. Registrer's Signature

DHMH 16 Rev 6/95

State Registrar

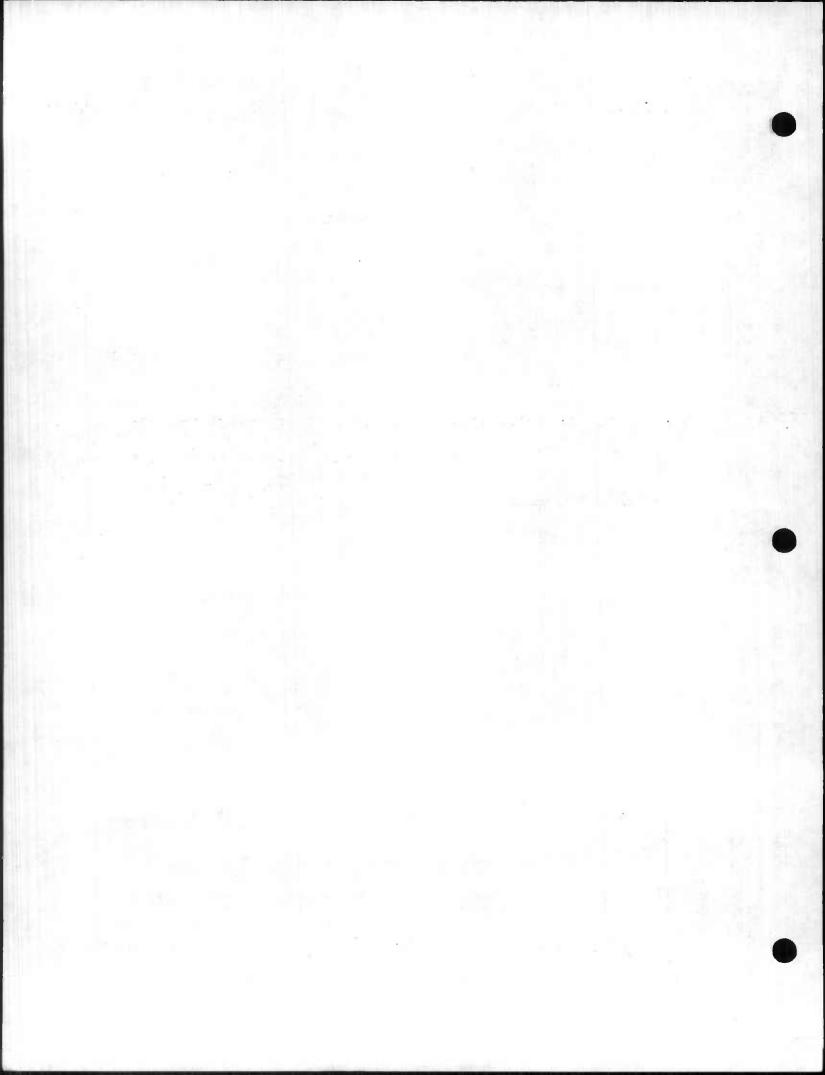
Benjamin 31. Dete filed (Month, Day, Year)

MAR 1 6 1999



State of Maryland / Department of Health and Mental Hygiene 0 0212

					Cert	tificate of	Death		R	eg. No.	U	0216
	<u>.</u>	1. Decedent'a Nama (First, Middle	e, Last)		ur i				2. Date of Deal Month	th Day	Year	3. Time of Deeth
	Physician /Medical	OLGA A. LIN	THICUM					1			99	11:15am
	Examiner	4e Facility Neme (If not institution	n, giva street and number)				4b. City, To	wn, or Lo	ocation of Death	4c. County		
(0)		729 COLORADO	AVE.				BALT	IMO	RE	N/	A	
	Funeral Director	5. Social Security Number 215-48-5052	1 N 2 YE	ge (In yrs. last bi	Yrs.	If Under 1 Yeer Months Deys	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 05/15/		Coun	oleca (Stata or Foreign ntry) LAND
pue	1	Usuet Residence of Decedant 10a. Stete 10b. County		10c. City, Toy	wn or Loc	ation					1	10d. Inside City Limits
Grad	of age	MD N/A										1 ☑ Yes 2 ☐ No
96	be notified	10e. Street and Number	<u> </u>		DAI	TIMORE		_	1	0g. Citizen of \	What Cour	ntry?
49 46	25s or mit be	729 COLORADO	AVE.			2121	0			USA		,
Maryland 21215-0020	af, or herre 23a or 28a-f show Examiner mark be notified at by Funeral Director	11. Marital Status 1 Never Married 2 Merr 3 X Widowed 4 Divorced	12. Was Decedent Armed Forcas? ied 1 Tyes 2 15 If Yes, Give Year or Detes:		lf.	as Decedent of F Yas, specify Cub ☐ Yes 2 No	an, Mexicar	n, Puerto	ecify Yas or No- Rican, etc.)	14. Raca - American Indian, Bleck, White, etc. Specify: WHITE		
5-002	te da	15. Deceden	'a Education	168	a. Decede	ent's Usual Occup	pation			16b. Kind of B		
1215 within 7	ygiene. Nr the Medical. Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	ind of work done O NOT use retire	during mos d)	t of work	ing			
27	The state of	12YRS	Consge (1 vol.		OUSE	EWIFE				HOMEM	AKER	
pu &	It's o	17. Father's Nama (First, Middle,	Last)				18. Mothe	ar's Name	e (First, Middle, Maiden Surname)			
/all	o de de	HENRY E. ALL	IE (C. GRIFFITH								
any	and la ma	19e. Informant's Neme/Reletions	hip (Type, Print)	19	b. Malting	Addrass (Street	and Numb	er or Run	al Route Number	City or Town,	State, Zip	Code)
	1 and 4ealth em 27 ther tr	BARBARA HALLA	M (DAUGHT)	ER) P	.0.	BOX 81	STO	NE I	RIDGE N	IEW YO	RK 1	2484.
0		20e. Method of Disposition	- 55			ition (Name of etory or other ple	ce)	1	Deta	20c. Location -	City or To	own, State
Pages		1 Burial 2 Cremetion 4 Donation 5 Other (S	3 ∐Removel from Stete pecify)			EN MEM		RK (03/19/9	9 BAL	то.,	MD.
Balti	Departmen mportant: iny injury zice	21. Signature of Funerel Service	Licensee		22.	Nama end Addre	ss of Fecili	ty				
m a	STER	Willean	Parit		HE	ENRY W.	JEN	KINS	S & SON	IS CO.	212	
		23a. Part1. Enter the disease, or ahock, or heart failura. List	complications that cause	the death. Do							212.	Approximete
DI	hydiolan	ahock, or heart failura. List	only one cause on each li	ne.								Intervet Between Onset end Death
	nysician Medical	Immedieta Cause (Final	0.0	ute	<1	cole						2
	xaminer	diseasa or condition resulting in death)	a. ac								- 1	2 weeks
	i i			Due to (or as a	consequ	ence of):						
r 68760, difficate be executed	physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying										
X 68760,	D	Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of):										
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P.O.	ched ched	Part II. Other significant condition	ns contributing to death b	ut not resulting	in the und	derlying cause give	en in Part I	l.				o the cause of death?
م بؤ	de to	8.0							1 U Y	98 2 No	3 Pro	bably 4 Unknown
Records, P.O. Box	ate has been signed by the ettend, page 2 should be detached for us. Completed by Physician/								24a. Wes a perform		av co	ere autopsy findings allable prior to implation of causa daath?
C 2	age 2 omp								1 D Y	s 2 No	1[□Yas 2□ No
E E	certificate rector, pag	25. Was casa refarred to medical					26 Place	a of Doet	h (Check only on			
of Vita Physician:	direct O	examiner? 1 ☐ Yes 2 ☑ Ño	Hospitet: 1 Inpatie	ent 2 ER/O	utnationt	3□ DOA Oth			me 5 A Raside		ner (Snecil	6/1
O	eral di	27. Manner of Death	28a. Date of Inju		Time of	28c. tnju		aroung 110	28d. Describe h			77
O P	After After a fundament	1 Naturet 5 Pending		y Year)	tnjury		Yas 2	No				
Division of Vital or Attending Physician: 1	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could r 4 Homicida daterm	ned 289. Place of in	ury - At homa, f c. (Specify)	arm, stre	et, factory, office			28f. Location (Si City or Town	treet and Numb	ber or Rure	el Route Number,
	S To S											
• Hosp	n 24 hound he Fundal hierary file	29a. Certifier for Certifying (Check only one)	g Physician: To the best Examiner: On the basis o end menner st	examinetion ar	e, daath ond/or inve	occurred et the til estigation, in my c	ma, data en opinion, dee	id place, ith occuri	end dua to the cared at the time, d	ause(s) end mo ate end pleca,	end due to	tated. o the cause(s)
9	To the	29b. Signatura and title of certifier		0		29c. Licens				9d. Data signe		Dey, Year)
	2 - 0	V/A	thous D.	C.	an	021	20.	5		MARE	415	11999
		30. Nama and address of person		leath (Item 23a)	(Type, P	Das	C4 6	2.0.	to IM-1	2170	(,	
7		OU A Kiley	GBMC		14- 0	noncos	37. 17		rid	7120		
	State Registrar	31. Dete filed (Month, Day, Year)	N.	ar'a Signatura	S.	Louis	/					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month CARRIE SCHUELER LARKIN 08:25 AM 03 12 99 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Villa Rosa Home Mitchellville Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days 1 □ M 2 🖾 F 215-05-2722 96 Yrs. Director July 28, 1902 Maryland Usual Residence of Decadent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at MD Prince Georges Bowie 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 12206 Maycheck Lane 20715 U.S.A. Items 23a Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiena. Important if Item 27 is marked other than "neturel". or learny injury or other traumetic event ☐ Yes 2 ☑ No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White à 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede comp 16b. Kind of Business/Industry completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Schueler Mamie Nizer 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) James Larkin/Son 12206 May Check Lane Bowie, Maryland 20715 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 3/16/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc. 21. Signature of Fu 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, on each line. Approximate Interval Between Onset and Death **Physician** Athero Sclerotic Heart Disease /Medical Immediate Cause (Final disease or condition resulting in death) Examiner The lew requires that the death certificeta be axecuted Exam attanding physician end for use as the burial-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physiclan/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to Records, Š 24b. Were autopsy findings available prior to Be Completed Lisordi 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Pruneral Director: After this certificately lilled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manper of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely lilled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner es steted.

**Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

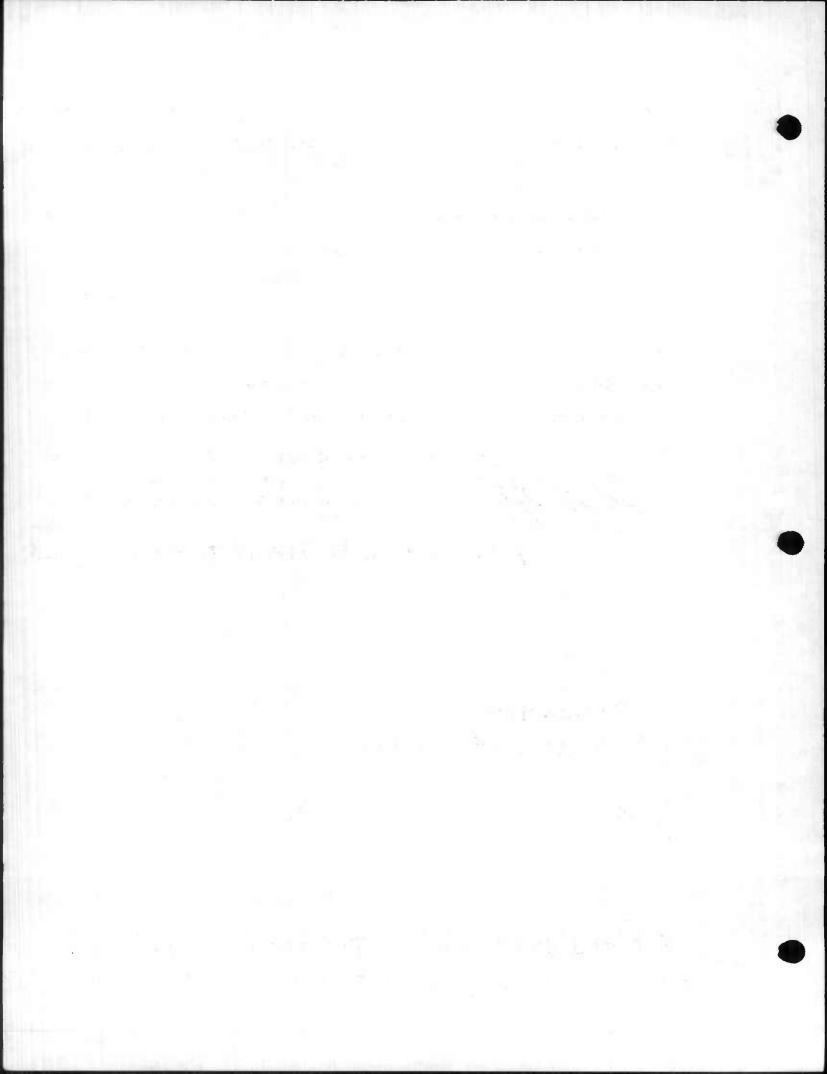
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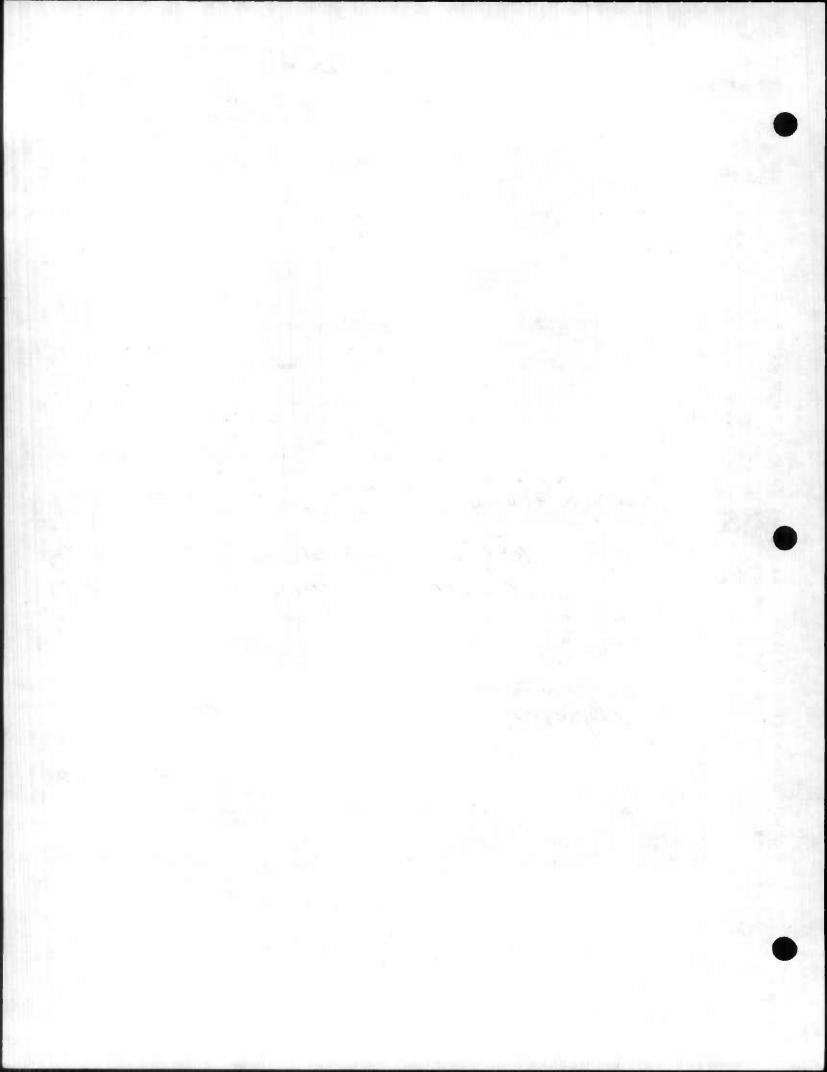
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31. Date filed (Month, Dey, Year)

32. Registrat's Signature



		State of Maryland / Department of Health a Certificate of Death		rgiene Reg. No.	08214
	Physician	1. Decedent's Nama (First, Middle, Last) Casper Winfield McNeal	2. Data of De Month March	07 ^{Pay} 1999 ^{ee}	3. Time of Death 12:58 PM
	/Medical Examiner		own, or Location of Deat sdowne	th 4c. County of D Balti	
	Funeral Director	5. Social Security Number 213-01-2883 6. Sex 1 [X]M 2 F 84 Yrs. 6. Sex Months Days Hours	24 Hrs. 8. Data of Bir Min. 09/01	th ay. Year) 9.1	Birthplaca (State or Foreign Country) Maryland
	f ahow	Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location Maryland Baltimore Lansdowne			10d. Inside City Limits 1 ☐ Yas 2 🛣 No
	fier death with the Mai r thema 23a or 28a-fai fine mint be notified Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	
	a 23a	121 Ridge Avenue 21227	inin? (Snacihi Vas or N	United	States
020	Dy Vi	If Yes, Giva 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Wildowed 4 ☐ Divorced Year or Datas:		Black, W Specify:	
21215-0020	ed within 72 hours yglene. Ar then "natural", f. the Medical En Completed by	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 9 th 16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired) Maintenance	it of working	16b. Kind of Busine Steel C	
	tal Hygle d other event, it		er's Name (First, Middle		ompany
/lan	should be filed ind Mental Hygi i merked other umatic event, To Be Co		argaret	Hildri	.ch
, Maryland	alth ar 27 le r treu	19e. Informant's Name/Ralationship (Type, Print) Susan A. Petrusik/ Daughter 19b. Mailing Address (Street and Number 121 Ridge Avenue		per, City or Town, State , Maryland	
Baltlmore,	Peges nent of ant: If It ury or o	20a. Mathod of Disposition 1 🖾 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Pa	Data ark 3/10/99	20c. Location - City Glen Burn	
Balt	pemit. Peg Department Important: I any injury o		ral Home Avenue Ba		aryland 21229
	Physician /Medical Examiner	23a. Part 1 Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as shock or heart failura. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequency of):	cardiac or respiratory e	irrest,	Approximate Interval Between Onset and Death
x 68760,	certificate be executed ding physician and se as the burlal-transit	Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of):	5		P
Box	the death certification by the attending ached for use as hysician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23b. Did	tohacco use contrib	ruta to the cause of death?
s, P.0	that ded b	Emphysema	OB	/	Probably 4 Unknown
Records	aw requires to been so a should pieted			s an autopsy omed?	tb. Ware autopsy findings available prior to complation of cause of death?
I B	The law page 2		10	Yes AND	1 □ Yas 2 No
VItal	clan: entific ector.	25. Was case referred to medical axaminer?	e of Death (Check only		
of	2 00	27. Manner of Death Salatural 5 Pending (Month, Day Year) 28b. Tima of Injury 28b. Tima of Injury 4 Work?		idence 6 Other (S how injury occurred	Specify)
Division	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be detarmined 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)	28f. Location ((Street and Number of wn, Stata)	r Rurat Routa Number,
	Ne Hospital n 24 hours Ne Funeral pletely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date an analysis of axamination and/or investigation, in my opinion, dea and manner stelled.			
	within To the comple	29b. Signature and titla of certifier 29c. License number	44	29d. Date signed (M	lonth, Day, Year)
)		30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 2717 Hammonds B	Ferry Road,	Lansdowne	e, Md. 21227
	State Registrar	31. Data filed (Month, Day, Year) MAR 1 6 1999 Server G. Loca V.			



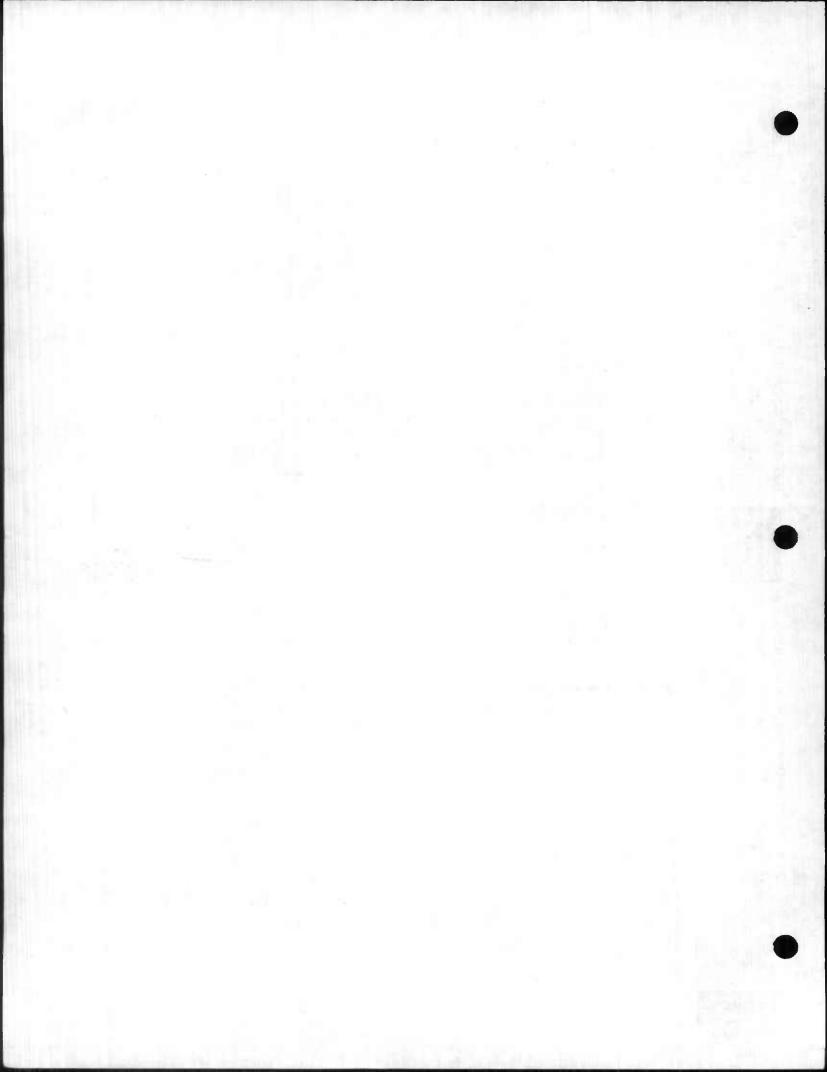
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

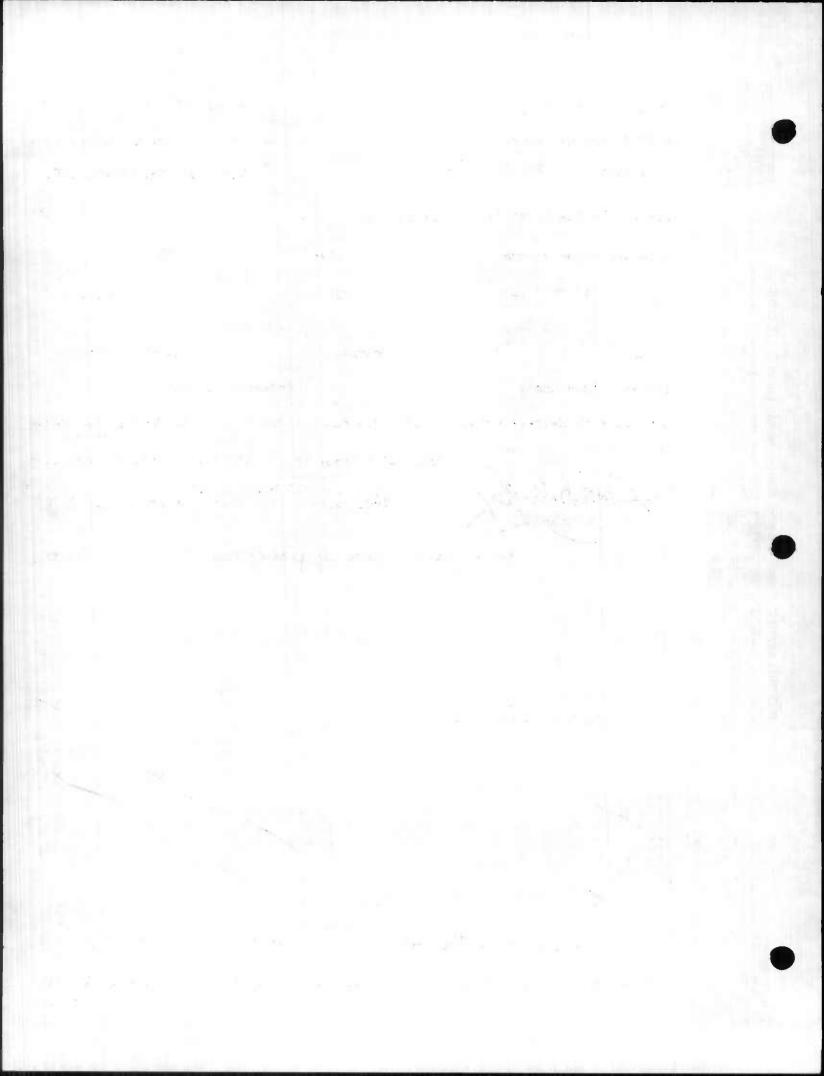
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/Medical	E	dward Paul	Moylan				march		999	7.00 P.N		
Examiner	4a Fecility Name (If not institution, give					4b. City, Town, or L	ocation of Deat	h 4c. County	of Deeth			
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Funeral	5. Social Security Number 6. S	Sex 7. Age		NUL	nder 1 Year tha Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	th ey, Year)	9. Birthple Count	ece (State or Foreign		
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N THE CO	Maryrana Aine A	runder		rasc	adena					TIL TES ZONO		
vith the Marine of the notified be notified Director	10e. Street and Number			10f	. Zip Code			10g. Citizen of \		ry?		
23a	1084 Notley	Court			21	122		U	.S.A.			
r tems 23s nos must	11. Merital Status	12. Wes Decedent E Armed Forces?		13. Wea D	ecedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Rac	e - America			
A P E		1 ☑ Yes 2 ☐ N If Yes, Give	• 1953		s 2⊠No			Specify				
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or thems 23a or 28e-f ahow mit, the Medical Example must be indiffed as Completed by Funeral Director.	3 Widowed 4 Divorced	Year or Dates:	1956					Opecing	Whi	te		
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and Mental Hyginal and Mental Hyginal Hyginal Extra and Mental Hyginal Extra and To Be Co.	Mar	ctin W. Moy	ian			Ange]	ina Bo	orscella				
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565	Denise I.Moylar	n Wife	10	84 Not	cley C	ourt Pasa	adena, Ma	aryland	21122			
f Heal	20a. Method of Disposition		20b. Place of	Ob. Place of Disposition (Neme of cemetery, cremetory or other place)				Dete 20c. Location - City or Town, Stete				
nd: H its	1X Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Contr						ery March 15,1999 Balt			to.Md.		
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Departr Importu any Inju	21. Signature of voltage convice Esse	4 4 -		McCu	illv-P	olvniak E	uneral	Home, P.	Α.			
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1 th 2 of	1 Netural 5 Pending investigatio	(Month, Day	rear) th	jury M		Yes 2 □ No						
rs after death. el Director: After tied in by the funera	3 Suicide 6 Could not b	288. Place of Inju	ry - At home, far	m, street, fe	ctory, office			Street end Numl	ber or Rura	Route Number,		
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THE THE CO		nysician: To the best of	my knowledge	death occur	rrad at the tir	ne date and place	and due to the	cause(s) and m	enner es st	nted		
in 24 hours he Fune pietely fil edical	(Check only 2 Medical Exar	niner: On the basis of and manner stat	examination and	or investiga	ation, in my o	pinion, death occu	rred st the time.	dete and plece,	and due to	the cause(s)		
within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Medical Certification:	29b Signature and title of gertifier	war malinot did			29c. Licens	e number		29d. Date signe	ed (Month. I	Dey, Year)		
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	30. Neme and address of person who	completed cause of de				0 = 11	210					
	DK. SKID S	HARIF	NORT	4 K	RUN	OEL Y	MARA	M. N	20			
State	31. Dete filed (Month, Day, Year)		r's Signature	1	1							
Registrar	MAR 16	1999		D.	160850	bal						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** Thomas Edison Mundy, II 10, 1999 3:07PM March /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner 4610 Josephine Avenue Beltsville Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number Birthplece (Stete or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Deys 1 X M 2 □ F Months 52 Yrs. 217-44-9977 Director Nov. 29, 1946 Wash. D.C. Usual Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Magnetic Examinar mass be notified. 10d. Inside City Limits 10e Stete 10h County 10c. City. Town or Location 1 ☐ Yes 2 No Maryland Prince George's Beltsville Director 10e. Street end Number 10f Zio Code 10g. Citizen of What Country? 4610 Josephine Avenue 20705 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 10 Yes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorcad Completed 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Courier All-Star Courier 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Thomas Edison Mundy Katherine E. Haikey 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) t9a. Informant's Neme/Reletionship (Type, Print) Katherine E. Haikey/ Mother 1501 Old Black Horse Pike Blackwood, NJ 08012 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 3/15/99 Suitland, Maryland 21. Signature of Fefferal Service Licer 22. Name and Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road L
d the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, MD 20707 Laurel, Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 3mas metastatee conce; pancreas Examiner Due to (or es e consequence of): Examiner physician and s the bunal-transit The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): ettending p for use es 80 Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signad by the e 1 Yee 2 No 3 Probably 4 Onknown atterasi Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? should b Completed 24e. Wes en autopsy performed? cartificate has b lirector, page 2 s 1 ☐ Yes 2 No 1 Yes 2 0 No al or Attending Physician: The saftar deeth.

I Director: After this cartificated in by the funeral director, pa 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 20 No 28c. Injury et Work? 28d. Describe how Injury occurred 27. Menne of Deeth 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of 1-2 Neturel 5 Pending 1 ☐ Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours after Funeral Dire letaly filled in b Hospital 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. edical To the Hosp within 24 hos To the Fune completaly fi 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end manner stated. (Check only 286. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) han Dewelden 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WELTZ 7525 Orner Orcentralt MD yearing G 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature MAR 1 6 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

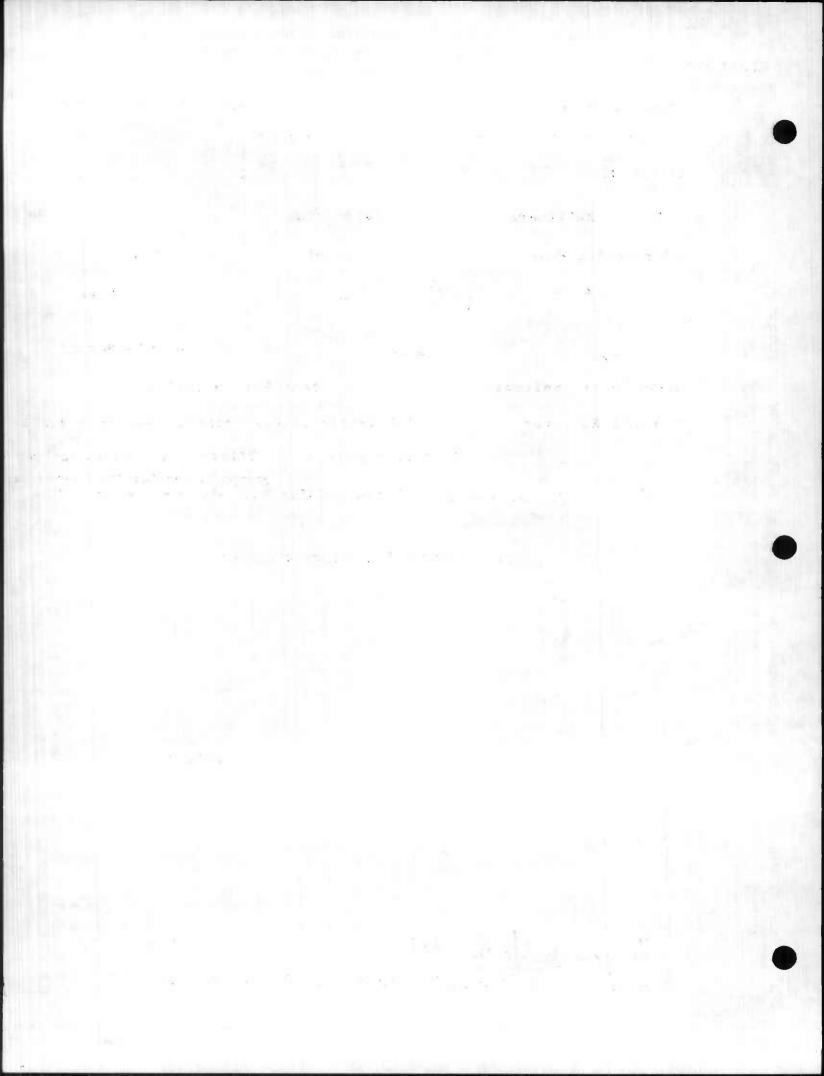
JOHN MULV	ANEY			Cert	ificate of	Death		Reg. No.	U	5611		
Physician · /Medical	1. Decedent's Name (First, Middle	e, Last)					2. Date of Month	Day	Year	3. Time of Death		
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Funeral	5. Social Security Number	6. Sex 7	. Age (In yrs. la	ast birthday)	If Under 1 Yea		Hrs. 8. Date of	Birth Dey, Yeer)	9. Birthp	place (State or Foreign		
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r 284	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?		
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should be ind Mental marked o	John Robert	Mulvaney				Anna	Teresa	eresa Juliano				
2 sho end is me	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Street	mber, City or Town	own, Stete, Zip Code)					
	Virginia Mul	vaney		1202	Getti	g Road	,Balti	nore, Ma	ryla	and 21237		
5 5 5 0	20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or To cemetery, cremetory or other place) 20c. Location - City or To cemetery 20c. Location - City or To cemetery 3/18/99 Baltimor											
pemil. Pages 1 er Department of Hea Important: If Itam 3 eny injury or other	21. Signature of Funeral Service		1				_			Funeral H		
40 E 8 a	/ Maria	J. gens	in	263	S. Co	nkling S	St., Bal	timore, M	aryla	and 21224		
Physician	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that can only one cause on ea	used the death. ch line.	. Do not enter	the mode of d	ying, such as ca	rdiac or respirato	ry arrest,		Approximate Interval Between Onset and Death		
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a Arteri	Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):									
icete be executed physicien end s the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Linderbing	b	b						i	N-HOLL		
ficate be exectly physicien er	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury		540 10 (0. 40 2 00.00444.102 0).									
ysicie	O thet initiated events	C	c									
T 000 .	resulting in death) Last											
eath cert attendin for use		d							i			
death cert e attending ed for use	Part II. Other significant condition	ons contributing to dea	th but not resul	Iting in the und	lerlying cause of	given in Part I.	23b.	Did tobacco use co	ntribute to	o the cause of death?		
het the od by the deteche	yar Yara									bably XX Unknown		
6 5 6	eted by						F	Vas an autopsy enformed? PECTION	av	ere autopsy findings allable prior to impletion of cause death?		
sician: The law requir certificate hes been s irector, page 2 should	d d							☐ Yes 35No		Yes 2□ No		
certificate	25. Was case referred to medica	ı				26. Place of	Death (Check o					
P 35	examiner?	Hospital:	patient XX	R/Outpatient	3□ DOA	ther:		Residenca 6 □Ott	er (Specif	(v)		
Affar this funerel d	- Ayres	28a. Date of (Month)		28b. Time of Injury	28c. Inj	ury at ork?	28d. Descr	ibe how injury occur		77		
the Hospital or Attending I hin 24 hours effer death. the Funeral Director: Affer mpletely filled in by the fune	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place o	f Injury - At hor g, etc. (Specify)	me, farm, stree		□ Yes 2 □ No e	28f. Locati	on (Street end Num. Town, State)	ber or Rure	el Route Number,		
Hospital or Attending 24 hours after deeth. Funeral Director: Afte letely filled in by the fune		ng Physician: To the b	est of my know	viedge, death o			place, and due to	the cause(s) and m				
thin 24 h	(Check only 2X) Medicat	Examiner: On the bas and manne	is of examinetic		stigation, in my	opinion, death		and due to the cause(s) and manner as stated. red at the time, date and placa, and due to the cause(s)				
7576	29b. Signature and title of certifie	ir a			29c. Lice	nse number		29d. Date signe	d (Month.	Day, Year)		

State Registrar

29c. License number UW

O.C.M.E

29d. Date signed (Month, Dey, Year) MARCH 14, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2. Data of Death Month Helen Mc Carthy .00 am 4a. Facility Nama (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Ridge Copper Sykesville Carroll 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 6. Sax 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 066-10-4183 Days 1□ M 2 F 8 Yrs. ORK Usual Rasidance of Dacadant 10a Stata 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yas 2 M No If Yes, Give Yaar or Datas: 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Navar Married 2 Married 1 Yas 2 No White Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Etamantery/Secondary (0-12) College (1-4or 5+) COM telephone ner's Name (First, Micidle, Last, 18. Mother's Nama (First, Middle, Maidan Sumama) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City of Town, Stata, Zip Coda) Stolle Glen Alm, Ma Date , 2 20c. Location -20b. Placa of Disposition (Nema of cematary, cramatory or other placa) Malch 1999 20a. Mathod of Disposition City or Town, Stata Burial 2 Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Moreland 21. Signeture of Punaral Sarvica Licensaa 8800 Enter tha diseasa, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or heart fellura. List only one cause on each line. 21234 Approximate Intarval Betwaen Onset and Death Immediete Causa (Final Years diseasa or condition rasulting In death) Dua to (or es a consequence of) Sequentially list conditions, if eny, laading to immediate cause. Entar Underlying Causa (Diseese or injury that initieted avants rasulting in death) Lest Dua to (or as a consequence of) Dua to (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Ø No 3 Probably 4 Unknown ON 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en autopsy 1 Yes 2 No 1 ☐ Yas 2 No

Physician /Medical Examiner

The law requires that tha death certificata be executed

use

this certificate

After

filled in by the funeral director,

completaly

P.O. Box 68760.

Records.

Division of Vital

Hospital or Attending Physician:

To the Hospital or Attendit within 24 hours aftar death. To the Funeral Director: A

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be 2

Funerai

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Hygiene.

. Peges 1 end 2 should be fill ment of Health and Mental Hent: If item 27 is marked oth Jury or other traumatic even

permit. Pege Department of Important: If any injury or

filed within 72 hours efter death with the Marylend

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ 25. Was casa rafarrad to madical axaminar?

physician end s the burial-transit 88 cate has been signed by ; paga 2 should be detact Be Completed Medical Certification: To

5 Panding invastigation

6 ☐ Could not be datarmined

1 Yas 2 No

27. Mannar of Death

1 Natural

2 Accident 3 Suicida

4 Homicida

26. Plece of Deeth (Check only ona)

Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascriba how Injury occurred 28c. Injury at Work?

1 Yas 2 No

Location (Streat end Number or Rural Routa Number, City or Town, Stata)

12 Certifying Physician: To the best of my knowladga, daath occurred at the tima, data and place, and dua to tha causa(s) and mannar as steted.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, data and place, and dua to the causa(s) and mannar stated. 29a, Cartifier 29b. Signatura end titla of cartifiar 29c. Licansa number

M.D. mestine

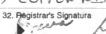
29d. Date signed (Month, Day, Yaar) 3/11/9

30. Nama and addrass of person who comptated cause of death (Itam 23e) (Type, Print) WRIGHT, ERNESTINE COPPER RIDGE

710, OBRECHT ROAD, SYKESUILLE MD21784

State Registrar

31. Data filad (Month, Day, Year) MAR 16



Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Place of Injury - At homa, ferm, straat, factory, office building, atc. (Specify)

28b. Tima of

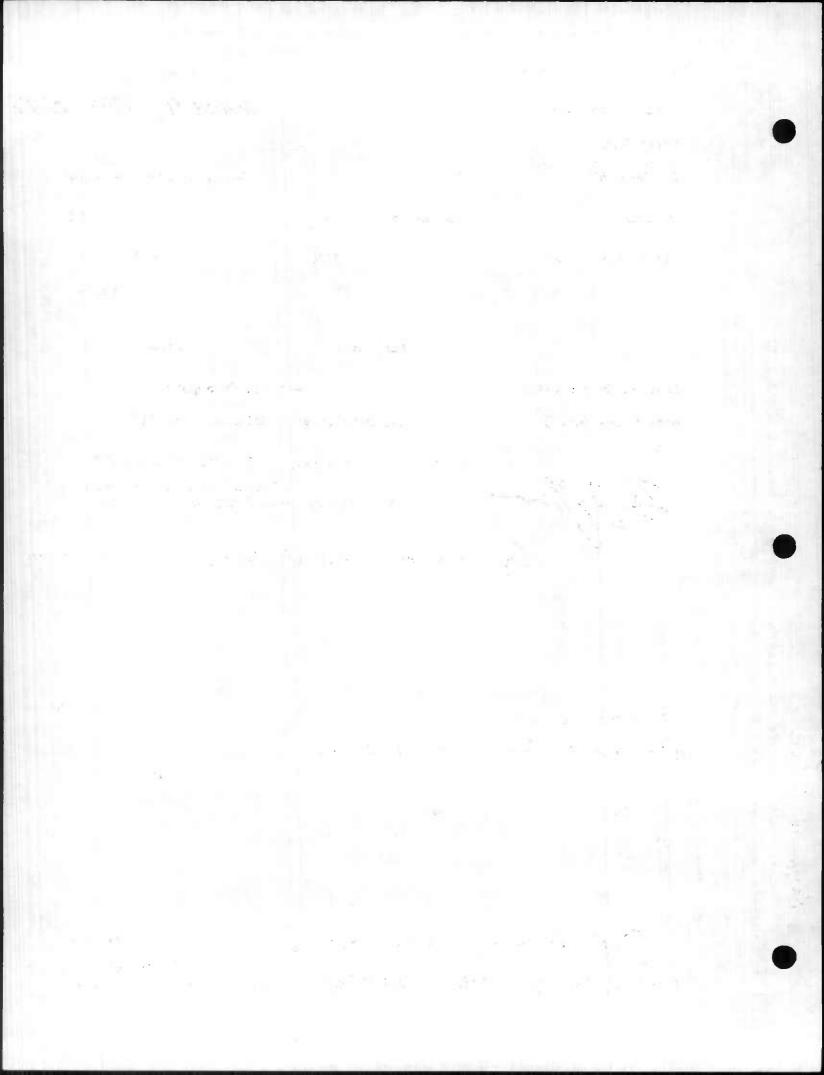
28a. Data of Injury (Month, Day Year)

pen



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	Item: 5 per F.H G-769 3/23/9	33 . 00	Ociti	ilcate of i	Death	2. Date of De	Reg. No.	2 3	ime of Deeth
	Raymond Charles Mc(Cue				MARCH	1 8	1999	15:26
· /Medical Examiner	4a Fecility Name (If not Institution, give street e			4	lb. City, Town, or I	ocation of Deet	h 4c. County	of Death	
	Caton Manor 5. Social Security Number 6. Sex	Baltimo	re	th	0 Pirthologo	State or Familia			
Funeral Director	5. Social Security Number 219-30-4064-A XX M 20 212-30-4064 Usual Residenca of Decedent	7. Age (In yrs. In 65		f Under 1 Year fonths Days	Hours Min.	8. Date of Bi (Month, Di Sept.		Baltim	ore
/land	10a. State 10b. County	10c. City	, Town or Local	ion				10d. in	side City Limits
Man Fred	Maryland	Balt	imore					24	Yes 2□ No
or 28a-f se notified	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Whet Country?	
s 23s	2813 Maudlin Ave.	s Decedent Ever in U.	2 42 1/4	212		nacih: Vac as Al	U.S.A.		hen
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. The returnal, or items 23a or 28a-f show important: If them 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Hedical Exercical must be notified at other. To Be Completed by Funeral Director	1 Never Merried XX Merried 1 ☐	ned Forces? Yes 2 VNo es, Give	If Yes, specify Cuben, Mexican, Pu				Bled Specify	k, White, etc. White	
ed within 72 hours att ygiene. ver than "natural", or rt, me Medical Exer- Completed by F	15. Decedent's Education (Specify only highest grade comp. Elementery/Secondery (0-12) Coll	leted)	(Give kin life. DO	NOT use retired	during most of wor	king		usiness/Industry	
od with	12	10g0 (1 401 57)	Mach	inist				ee1	
nd 2 should be file tith end Mental Hy 27 is marked other treumstic event,	17. Father's Name (First, Middle, Last)						, Meiden Sumen	10)	
hould light marks marks	Charles Grover McCue 19a. Informant's Name/Relationship (Type, Prir	nt)	19b Mailing	Address /Street	Margare			State. Zin Code)
emit. Peges 1 and 2 s bepartment of Heelth an mportant: If item 27 is n my injury or other treus MCs.	Mary mcCue (wife)	27			n Ave. Baltimore		nber, City or Town, Stete, Zip C e, MD 21203		
of Heer rem	20e. Method of Disposition	0.0	ace of Dispositi			Date		City or Town, S	tete
Peg ment: M ury or	1	from State		11 Ceme	1	3/13/99	Baltimo	re,MD	
Departrimporta any Injures.	21. Signature of Funeral Servica Licensee			ame and Addre	ss of Facility Lou	don Par	k Funera	1 Home	
	23a Part. Enter the disease or complications stock, or hear failure. List only one ceus	that caused the death	. Do not enter	20 Wilke the mode of dyin	ns Ave.	Baltimo or respiretory	re, MD 2	Appr	oximete
Physiclan /Medical Examiner		avemovs		Cancel				Onse	val Between of and Death
executed an end rial-transit	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury c.	Due to (or	as a conseque	nce of):					
sate be physicia the bu	cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest	Due to (or	as e conseque	nce of):					
certific nding p use es	d							1	
5 0 7 0	Part II. Other significant conditions contributing	o to death but not reco	Iting in the unde	arlying cause chr	en in Pert I	23h Did	tobecco use co	ntribute to the	ause of death?
at the death certiful the death certiful the attending etached for use elements.	- arch. Other arginicant conditions contributing	23b. Did tobecco use contribute to the c			4 Dunknown				
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requires that the been signed by the should be detached by the should be detached by Physical By Physical By Physi		er vdiovasc.	lar	diseas	e	24e. Was	s en eutopsy omed?	available	on of cause
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Mildred Rogers Munson March 1999 124 8:45PM 4e Fecility Neme (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare - Perring Parkway Center Parkville Baltimore 7. Age (In yrs. last birthday) Hours Min. 8. Date of Birth 10/18/1906 If Under 1 Year Months Days 9. Birthplace (State or Foreign Mar 9 1 and 5. Social Security Number 218-40-7654 10 M ADF Usual Residence of Decedent 10a. Stete 10b. County 10c City Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Baltimore City N/A 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 United States 3723 Delverne Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ANo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Merried Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 💆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemakey 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home 17, Father's Name (First, Middle, Last) Howell E. Rogers 18. Mother's Name (First, Middle, Maiden Sumame) Mary E. Watson 19e. Informent's Neme/Relationship (Type, Print). Charles G. Schweiger/friend 4716 Ballygar Road Baltimore, Mary Tand 21236 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremetion 3 ☑ Removel from State 20c. Location - City or Town, Stete Baltimore, Maryland 3/17/99 Greenmount cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Lidensee 22. Name and Address of Fecility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Pentl. Enter the diffeese, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart latiure. List only one cause on each line. Approximete Intervel Between Onset end Death Disease Immediete Cause (Final Bre disease or condition resulting in death) Due to (or es e consequence of) Revimson Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 28 No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 DNetural 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Examiner and attending physician for use as the buna Physician/Medical the 88 2 signed t by certificate Apital or Attending Physician: hours after deeth. Medical Certification: To To the Mospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the

P.O. Box 68760,

Division of Vitai Records.

Physician

/Medical

Examiner

Funeral

Director

ahoe

288-1

'natural', or items 23s or

72 hours after

Hygiene.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important; if them 27 is marked other that any Injury or other transmitted other than

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

MD

Director

Funeral

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Completed

Be

Completed 25. Wes case referred to medical examiner? Be 1 Yes 2 No 27. Manner of Peath

MI)

St Inte 30 f

29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier DUGA 29c. License number D31464 29d. Date signed (Month, Day, Year)

Balt.

21271

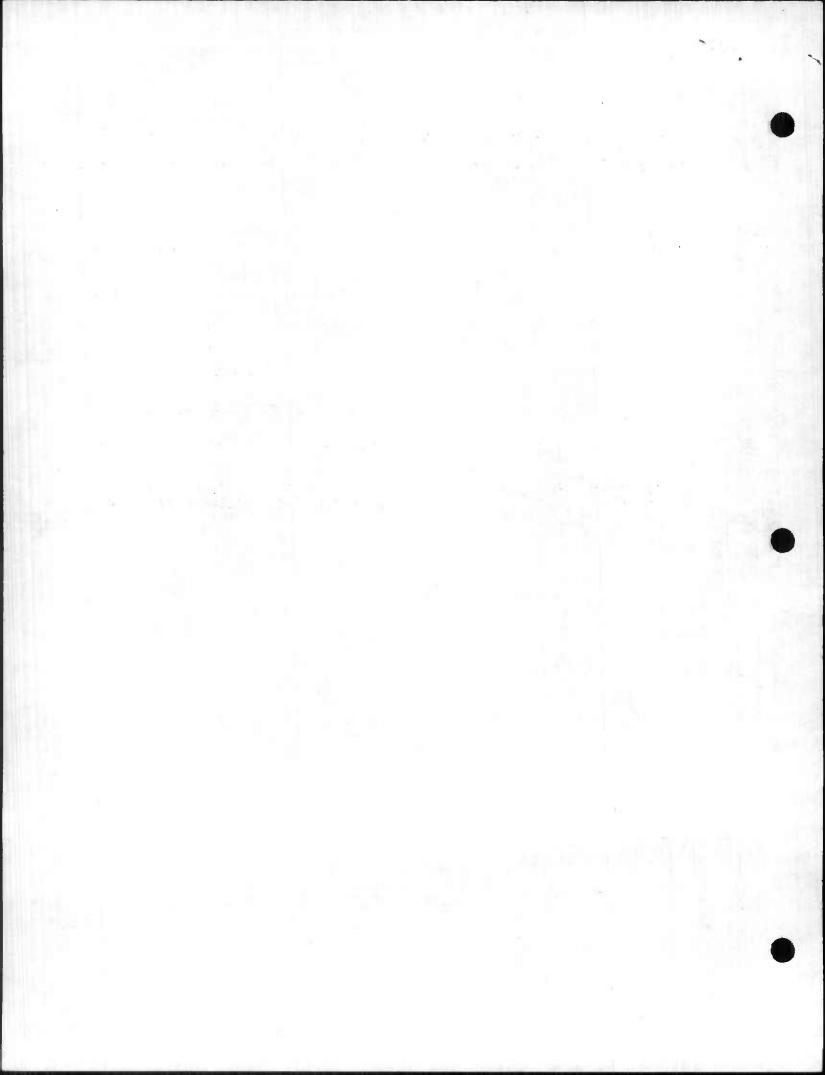
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. ItA+ Hm1 821 N. ENTAW SHOAIB

31. Dete filed (Month, Day, Year)

32, Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Deeth

3. Time of Deeth

		Decedent's Nama (First, Middle, Last)				2. Date of Deeth Month	Dey Yeer	3. Time of Deeth	
	Physician /Medical	MARY ELAINE MOREI	LAND			MARCH 14,	1999	8:00 AM	
1	Examiner	4e Fecility Neme (If not institution, give street and nu	m <i>bar)</i>		4b. City, Town, or L	ocation of Deeth	4c. County of Dee	ith	
		710 WINTON AVE.			FERNDALE		ANNE ARU	NDEL	
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. lest bir	rthday) If Under 1 Year Months Days		8. Date of Birth (Month, Dey, Ye	9. Bir	thplece (Stete or Foreign ountry)	
	Director	212-01-6282 1 M 2XF Usuel Residence of Decedent	SEPT. 3,	1918 MAR	YLÁND				
	yland	10e. Stele 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits	
	Maried	MARYLAND ANNE ARUNDEL		FERNDALE				1 ☐ Yes 2 € No	
	ith the Mar or 28a-f s be notified	10e. Street end Number		10f. Zip Code		10g.	Citizen of Whet Co	ountry?	
	23a 23a 23a 23a 23a 23a 23a 23a 23a 23a	710 WINTON AVE.		2	21061	U	NITED ST	ATES	
	r items 234	11. Merital Stelus 12. Wes Dec Armed Fo	edent Ever in U,S. orcas?	13. Was Decedent of If Yes, specify Cult	Hispanic Orlgin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Raca - Ame Bleck, Whi		
020	0 0	1 Never Married 2 Married 1 Yes If Yes, Gi 3 Widowed 4 Divorced Yeer or D	ve T	1 ☐ Yes 2 No	Specify:		Specify: WHITE		
2-0	hin 72 hours 3. In "natural", Med cal Ex	15. Decedent's Education (Specify only highest grade completed)	16e	. Decedent's Usuel Occu (Give kind of work done	during most of work	ing 16t	o. Kind of Business	/Industry	
121	212: d within giene. or then in m	Elementery/Secondary (0-12) College (1-4or 5+)	'Iffe. DO NOT use retire			DEMATI		
		17. Father's Neme (First, Middle, Last)		SALESCLEI		e (First, Middle, Mai	RETAIL		
id be fill be	CHARLES JOHN CUNRAD LE	r M 7 NINI							
7	E SEE	19e. Informent's Name/Reletionship (Type, Print)		o. Meiling Address (Stree	MAMIE JA		ity or Town. Stete.	Zin Code)	
Ma	2 8 8 3	DR. REV. RAYMOND T. MORI		31 Hall Roa			1701	-,,	
9	一工五五	20e. Method of Disposition	20b. Place o	f Disposition (Neme of			. Location - City or	Town, State	
UO.	Pages in it if it ry or or	1 → Burial 2 □ Cremetion 3 □ Removel from 4 □ Donetion 5 □ Other (Specify)	State	ry, crematory or other plot HAVEN MEM. I	I I		T.FN BIIDN	IE, MARYLAND	
Baltimore	Departm Departm mportar any Injur	21. Signature of Euperal Service Licensise	GDEN I	22. Neme end Addr	ess of Fecility			III, PHIRIDANE	
ä	Ped game	Nat all l		KIRKLEY-R				21.061	
		23a. Pert1. Enter the disease, or complications that	caused the death. Do	421 CRAIN not enter the mode of dy				Approximate	
	Physician	shock, or heert failure. List only one ceuse on a	eech line.		6			Intervel Between Onsat and Deeth	
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	eb.	30. Name and address of person who completed cause			MD 2106	1		1	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 1 per M.D G-769 3/16/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death AUGUST J. MAYNE Day 1999 March 10, 6:25 PM 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end nymber) 4c. County of Death Baltimore 610 S. Kenwood Avenue If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year, 12/28/1917 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 10 M 20 F Months Days Hours Yrs 81 216-16-1319 Maryland Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 610 S. Kenwood Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White WWII 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Spice Miller Spice Company 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) August Magdusauckas Josephine Valinkeviciute 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Baltimore, Maryland 21224 610 S. Kenwood Ave. Selma Mayne / Wife 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, crematory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematorium re of Funeral Service Lice 22 Name and Address of Facility Funeral Homes, P.A de 401 S. Chester St. Baltimore, Maryland 21231 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death PNELIMONIA Immediate Cause (Final disease or condition resulting in deeth) REBRO VASCULAR ACCIDENT. Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physiclan /Medical Examiner

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Division of Vital Records, P.O.

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Physician

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Haath and Mentel Hyglene.
ant: If Item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumetic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed

25. Was case referred to medical 2ENO 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending 2 Accident

investigation 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signatur

29c. License number

29d. Date signed (Mgnth, Day, Year)

empleted cause of death (Item 23e) (Type, Print)

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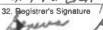
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29a. Certifier

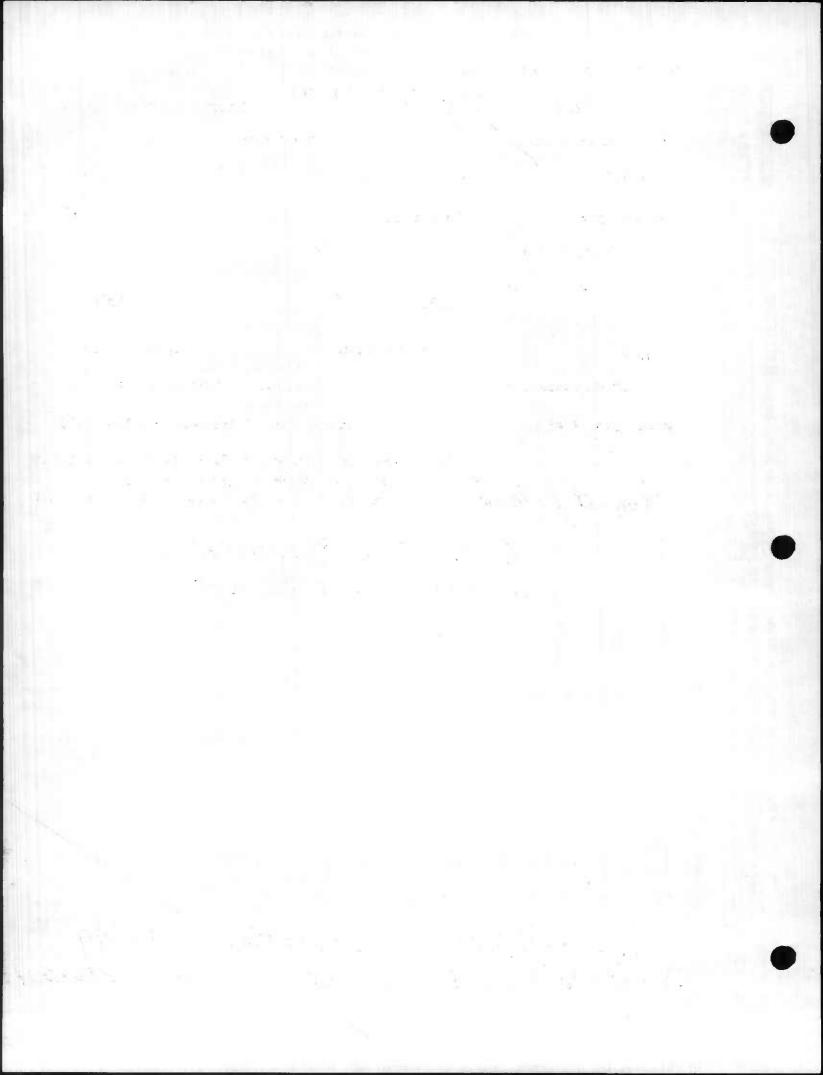
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State Registrar



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Physician Medical Examiner Walter Matthew Moorefield March 13, 1999 5:46 4a. Facility Name (if not institution, give streat and number) Westminster Nursing Center Westminster Westminster Vestminster Carroll Funeral Director Director Funeral Director Funeral Director Director Funeral Director Funeral Director Funeral Director Funeral Director Director Funeral Director Director Director Funeral Director Director Director Funeral Director Director Director Director Funeral Director Director Director Director Director	Contract of	11	Decedent's Name (First, Mich.)	idle. Last)		UE	ertificate of	реатп	2 Data of D	Reg. No.	0 (3. Time of De
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARKLAND 7:55 Am 1999 MARY MARCH 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street end number) 4c. County of Death RANDALLSTOWN BALTIMORE HOSPITAL CENTER NORTH WEST 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year Months Days If Under 24 Hrs. 6. Sax Birthplace (Steta or Foreign Country) 1□M 2XF 218-15-4964 Jamaica Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3511 Foxeliff Court 21133 Jamaica 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Spacify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) UNKNOON UNKNOWN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley Hibbert - daughter 11 Tahoe Circle, Owings Mills, Md. 21117 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata Woodlawn Cem. March 19, 1999 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn, Md. 21. Signetura of Funeral Service Licenses 22. Nama and Address of Fecility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117 Ellet th 23e. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dylng, such es cardiac or raspiratory arrest, shock, or heart faiture. List only one cause on each line. Approximete interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in deeth) Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Ceuse (Disaese or Injury that initiated events rasulting in death) Lest Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the undarlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

Box 68760 P.O. Records, Division of Vital or Attending Physician: 124 hours a To the Hosp within 24 hor To the Fune completely fi

> State Registrar

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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items 23a

permit. Pages 1 and 2 should be filed within 72 hours efter of Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten mortant: if Item 27 is marked other than "natural", or iten mortant of Item 1 in Mexical Exams each plays.

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After

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Certification: To

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Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

Funeral

by

Completed



HOUSE

Name and address of person who completed cause of death (Item 23e) (Type, Print)

PHYSICIAN

HARISH.

29c. License number

D 42723.

3745 FOXFORD BALTIMORE

29d. Date signed (Month, Dey, Year)

MRLAM RD MD 21236

MARCH

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31. Date filed (Month, Dey, Year)

29b. Signature and fittle of certifie

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State of Maryland / Department of Health and	Mental Hygiene	1225
Certificate of Death	Reg. No.	los los V
	2. Date of Death	3. Tima of Death

1. Decedent's Name (First, Middle, Last) Month **Physician** Richard Neumann March 1999 13 /Medical 4a Facility Nama (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vision Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Gountry) **Funeral** 219-28-440 Usual Rasidence of Decedent 10 M 20 F Q(0 Yrs. Director 10a Stata 10h Count 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examinations must be notined as Director 10a. Street and Numb 10f. Zip Code 10g. Citizan of What Country? 8626 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼ Yas 2 ☐ No If Yas, Giva Year or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Married Specify: White Baitimore, Maryland 21215-0020 1☐ Yes 2☑ No Specify λq 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nachinist 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Neumann 19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore punann 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata March 16 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Othar (Specify) 1999 21. Signature of Furtiral Service License 22. Name and Address of Facility vans 880C 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) a Chrone lymphocyte Examiner Dua to (or as a consequence of): Examine physician and s the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) USB BS

Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown

24a. Was an autopsy performed?

24b. Wara autopsy tindings availabla prior to completion of cause of death?

10:45AM

10d. inside City Limits

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Approximata Intarval Batween Onset and Death

twelve year a

1 Yas 2 No

1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only one)

1 Yas 2 No

Mal

25. Was casa rafarred to medical axaminar? 1 Yas 2 No 27. Manner of Death

5 Pending invastigation 6 Could not be 28a. Data of Injury (Month, Day Year)

1 Pinpatient 2 ER/Outpatient 3 DOA 28b. Tima of

28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yas 2 No

Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one)

1 Matural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

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Completed

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Medical Certification: To

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after death. Director: A

To the Hospital or within 24 hours at To the Funeral D

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier

29c. License number

29d. Date signed (Month, Day, Year)

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March 12, 1999

Baltmare

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

MO

Hospital:

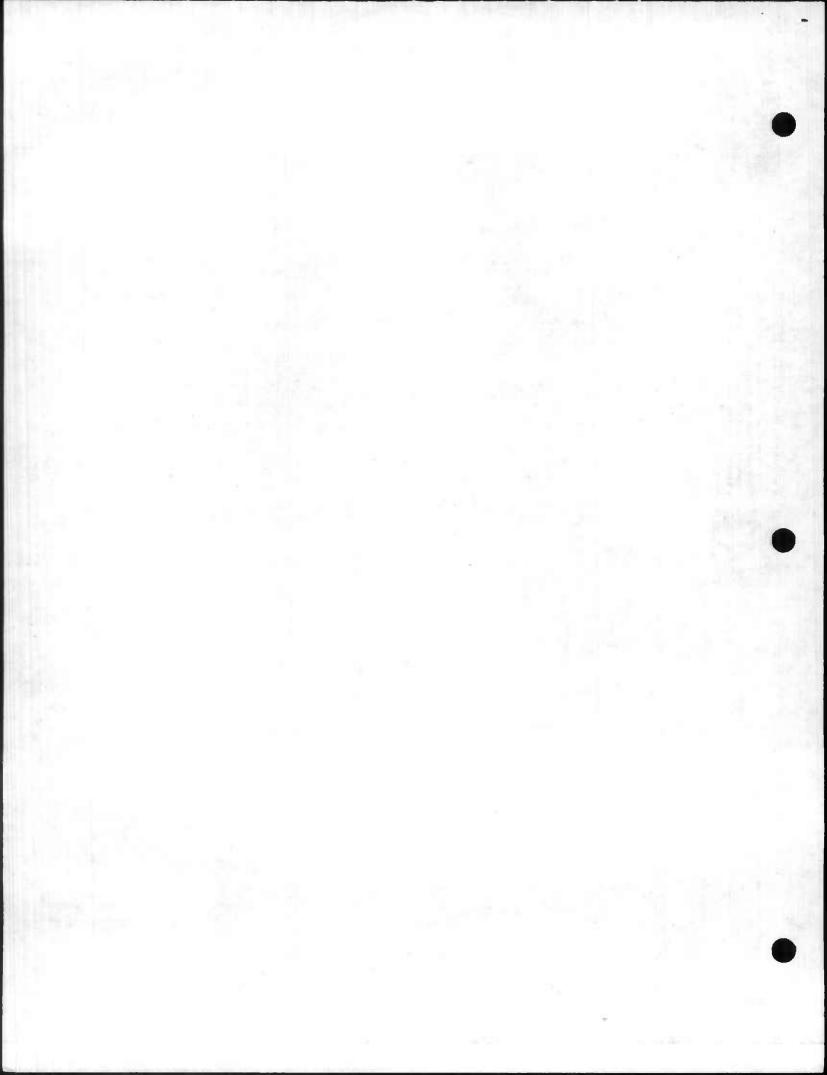
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32. Registrar's Signature

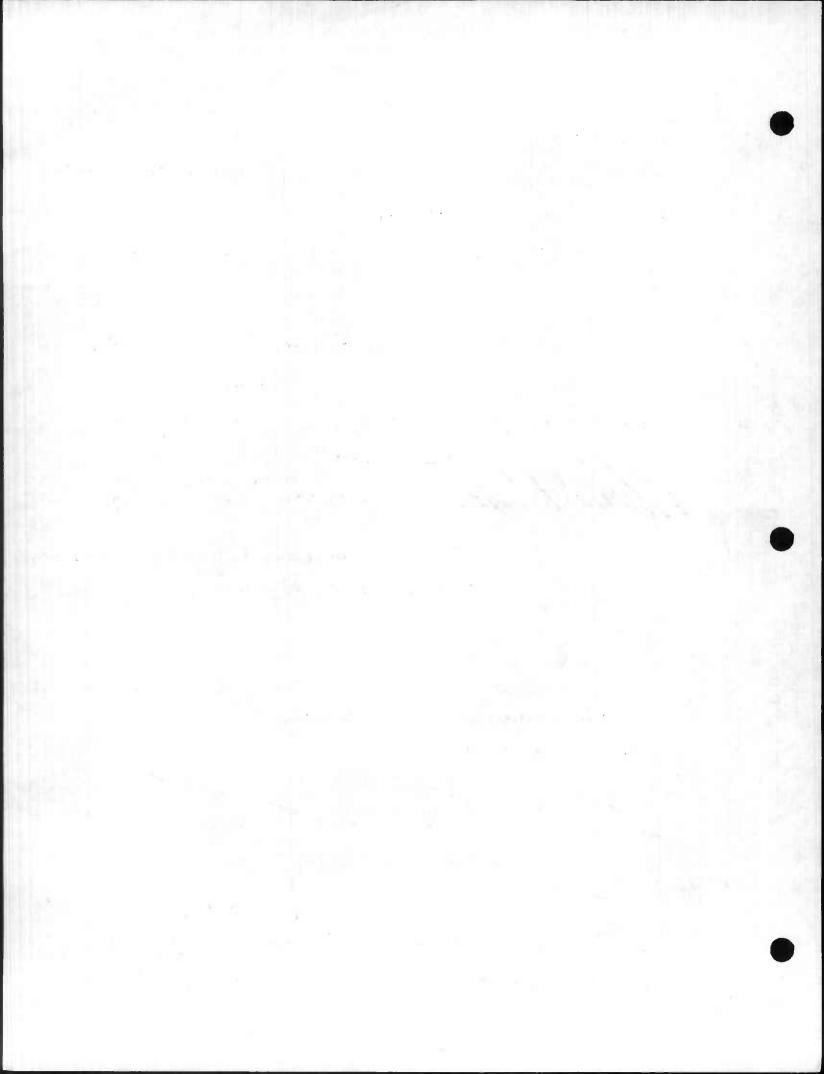
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State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey Month Yaer **Physician** GERTRUDE NOVAK 2:00 AM MARCH 10, 1999 /Medical 4e Facility Neme (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GENESIS BRIGHTWOOD ELDERCARE LUTHERVILLE BALTIMORE If Under 1 Yaar If Undar 24 Hrs. Hours Min. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign **Funeral** Months Deys MARYLAND 1 M 20 F Yrs. 217-01-5230 87 Director APRIL 24,1911 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No MD N/A BALTIMORE Director r than "natural", or items 23s or 28s-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 6711 PARK HEIGHTS AVENUE Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Rece - American Indien, Bleck, White, etc. hours after 1 Yes 2 No 1 ☐ Never Merried 2 ☐ Married b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: WHITE à 3 ☐Widowed 4 ☐ Divorced Yaar or Datas: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hyglene. ther then Elementery/Secondery (0-12) College (1-4or 5+) RETAIL BUYER RETAIL 12 permit. Pages 1 and 2 should be fin Department of Health and Mental Hy Important: If them 27 is manked oth any injury or other treumetic event 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be WISE FANNIE RUBIN LOUIS 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 6703 DARWOOD DRIVE, BALTIMORE, MD 21209 PHYLLIS HOFFMAN / NIECE 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 5 Other (Specify) BALTIMORE HEBREW BALTIMORE, MD 3/12/99 rai Şervice License 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. user 8900 REISTERSTOWN ROAD - PIKESVILLE, 21208 t caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and on each line. Approximate Intervel Between Onset end Death **Physician** gandrene of Lover Extremities /Medical tmmediete Cause (Finel weeks & with disease or condition resulting in deeth) Examiner VASCULAR Dease Examine Jen pheral 1ear bunial-transit Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last end Due to (or es a consequenca of): physician s the buria Box 68760 Physician/Medical Dua to (or as a consequenca of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? P.O. 94 signed by t d be detact 1 Yss 2 No 3 Probably 4 Unknown Chronic Obstructure Laura Records, þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy partormed? Stogren's Synarome peen has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica funeral director. 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Haturel 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be 3 Suicida 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, and due to the cause(s) end menner steted. (Check only one) To the P 29b. Signature and little of confiler 29c. Licansa number 29d. Date signed (Month, Dey, Year) attend . Na D17/18 30. Name and ad wito completed cause of deeth (Item 23a) (Type, Print) ess of perso 11TE. McRose Are SCHWARTZ M.D. 31. Dete filed (Month, Dey, Year) 32 Registrer's Signature State MAR 1 6 1999 Registrar

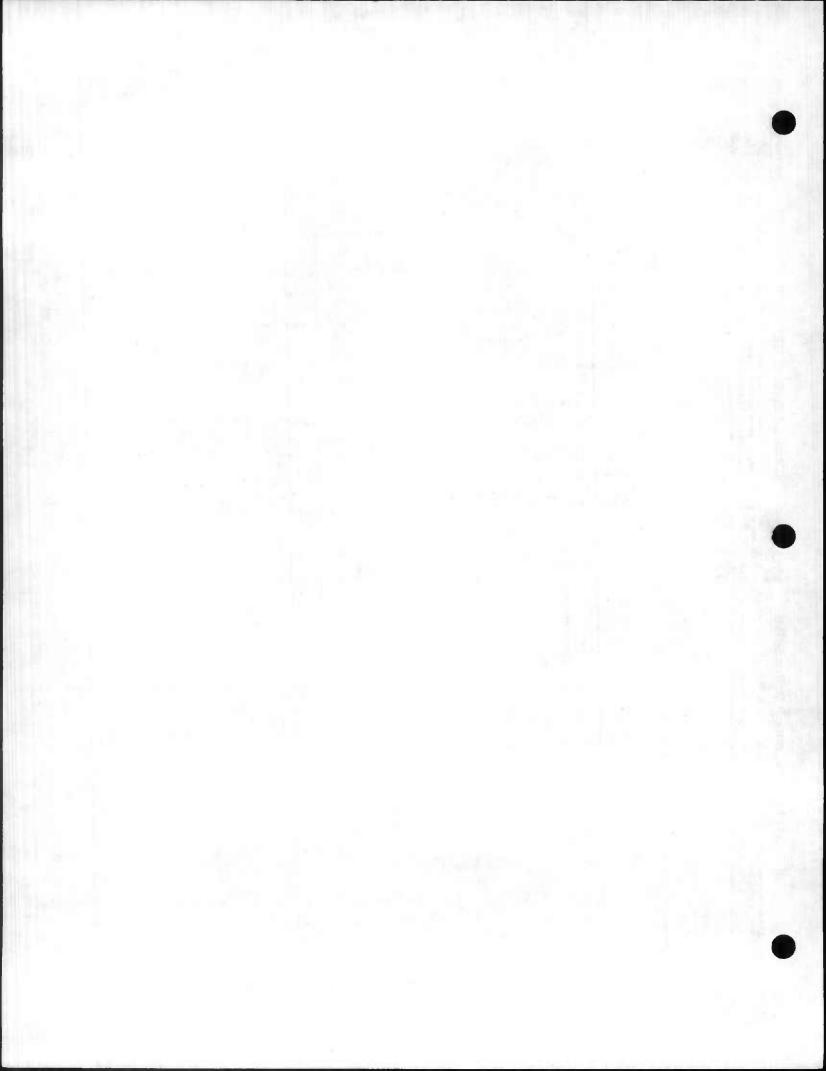


State of Maryland / Department of Health and Mental Hygiene \bigcirc

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Physician /Medical	James		Ne	eafsey					March			8:55am	
Examiner	4a Facility Name (e street and num	ber)				4b. City, Town, or Lo	ocation of Death	4c. County	of Death		
	763 Mesa Court Millersville 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Date								ille	Ann	e Aru	ınde1	
Funeral Director	5. Social Security N 040-30-		Sex 7 1XIM 2□ F	. Age (In yrs. last 60	birthday) Yrs.		1 Year Days	Hours Min.	8. Date of Birth (Month, Day May 3,	(, Year)	9. Birthpi Coun. New	lace (Stete or Foraign try) York	
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\$ 0 % D	763 Mes	sa Court				10f. Zip (211	08		try?			
	11. Marital Status		12. Was Deced Armed Ford	lent Ever in U,S.	13.	Was Decede	ent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	an Indian,		
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Baltimore, permit. Peges 1 a peparatin. Peges 1 a le peparatin til New any Injury or othe pace.	4 Donation 5 Other (Specify) Lakemont Memorial Gardens 03/16 Day 21. Squature of Europeal Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MI										1.401		
	23a, Part1, Enter to	ne disease/occom	plications that cau	used the death. D	1			ng, such as cardiac	~		1401	Approximate	
the death certificate be assecuted the death certificate be assecuted with the ettending physician and sched for use as the burial-transit whysiciany/Medical Examiner	Immediate Cause disease or condition resulting in death) Sequentially list coil any, leading to incause. Enter Unde Cause (Disease or that initiated events	nditions, imediate rhying injury	b	Due to (or as	e consec	quence of):	Les	last at	Neck				
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II Records, P.O. Box The lew requires that the death cer tate has been signed by the ettendir, page 2 should be detached for use. Completed by Physician/N		Hypa	-Ceps	Daw	_		-		24a. Was a perfor	an autopsy med?	ava	ore autopsy tindings allable prior to appletion of cause death?	
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f Vital Rystelan: The I secreticate hydrector, page	25. Was case refer	red to medical						26. Place of Deat	h (Check only or	ne)			
of Vita Physician: this certific ral director, I: To Be	axaminer? 1 ☐ Yes 2 🛱	No	Hospitel:	patient 2 ER/	/Outpatier	nt 3 DO/	A Oth	vor:	ma SatBesid		ner (Specify	()	
	27. Manner of Death	5 Pending investigation			b. Time of Injury		c. Inju		28d. Describe h				
Division of standing P as after death. In Director: After the funer led in by the funer. Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	200. Place 0	f Injury - At home , etc. (Specify)	, farm, str	eet, factory,	office		28f. Location (S City or Tow	itreet and Num n, State)	ber or Rura	l Route Number,	
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Cartifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the boniner: On the base and manne	is of examination	dge, death and/or in	occurred ai	t the tir	me, date end place, ppinion, death occurr	end due to the c red at the time, o	cause(s) and m date and place,	enner as st and due to	eted. the ceuse(s)	
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o co	30. Name and address Willia	ess of person who am E. Beł	completed cause irens, MI	of death (Item 23	a) (Type, HO11)	Print) / Aven	ue,	Ste. 100), Annap	olis. N	(D 214	101	
State Registrar	31. Date filed (Mont	n, Day, Year) R 1 6 199	32. Reg	plstrar's Signature		,		E-PA			44.1		

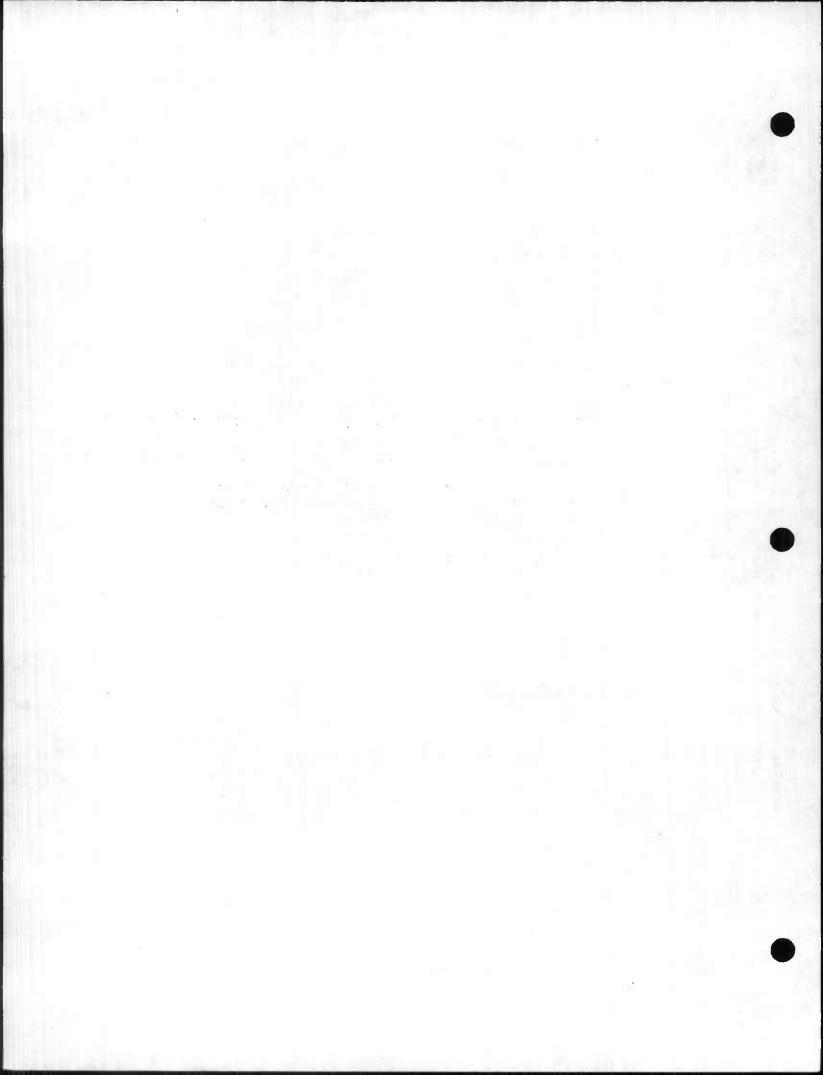
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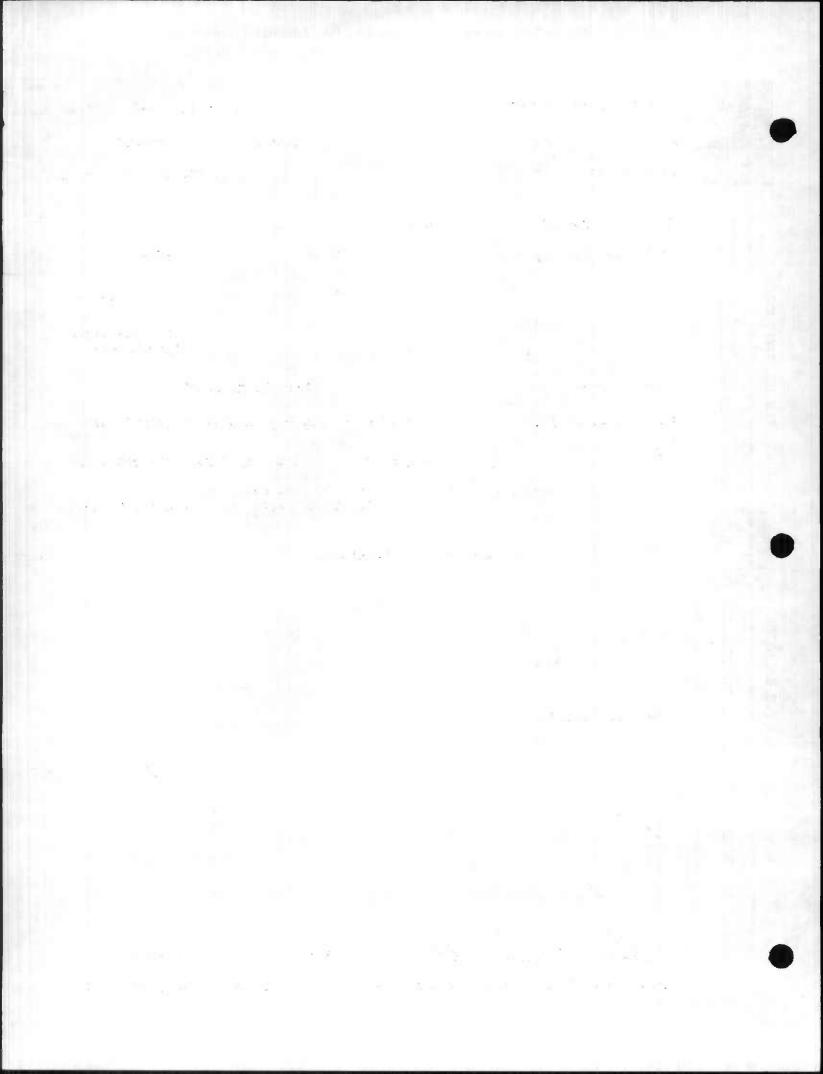


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** ROY W. OWENS 1:15 AM MARCH 15 1999 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner DEATON MEDICAL CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Yea Birthplece (State or Foreign Country) 6. Sex 8. Dete of Birth (Month, Day, Year) **Funeral** Days Hours 1√2 M 2□ F Months 58 213-36-5760 Director Maryland Usual Residence of Deceden the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 □ No Director Md. n/a Baltimore 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 1733 Patapsco Street items 23s 21230 Funeral USA death 12. Wes Decedent Ever in U,S. Armed Forces?

1 □Xes 2 □ No HYes, Give Yeer or Detes: 11. Merital Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" — any injury or other traumatic average. Black, White, etc. 1 Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify Completed by white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Construction Co. 12 superintendant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Roy Freeman Owens Dorothy Schafer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy Owens (Mother) 1733 Patapsco Street, Baltimore, Md. 21230 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 D Burial 2 □ Cremetion 3 □ Removel from Stete 3/18/99 Brooklyn Park, Md. 4 Donetion 5 Other (Specify) Holy Cross Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Cencer will Brain Melasksis. Examiner Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical thet initieted events resulting in death) Last Due to (or es a consequence of) USB I signed by the a Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No 12 per bension þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 ☐ Yes 2 No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28h Time of 28c. tnjury at Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No r deeth. 2 Accident 24 hours after deet 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and pleca, end due to the cause(s) end menner steted. within 2 2 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 055283 hus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hellimore MO 212.10 Elv. splet He JEL 1147 Jo-12 31. Dete filed (Month, Day Year) 32. Registrer's Signeture State MAR 1 6 1999 Registrar



					State	of Maryla		irtment of I <i>tificate of</i>		d Mental Hy	giene Reg. No.	08	229	
	Physici		1. Decedent's Nama (First Robert Lee		st) Liver					2. Date of D Month March	eath Day	Yeer	3. Time o	
	/Medio Examin		4a Facility Name (If not in	stitution, giv	a street and n	um <i>ber)</i>			4b. City, Town,	or Location of Deal			14:40	р.ш.
			8798 Doves Fly Way Laurel								Howa	rd		
	Funeral Director		5. Social Security Number 220-42-3635		Sex IOXM 2□F	7. Age (In yr. 51	s. last birthday) Yrs.	Months Days		lin. (Month, D.	ay, Year)		inthplace (State or Foreig Country) shington, D(
	pue »		Usual Residence of Deceding 10a. State 10b.	dent County		10c. C	City, Town or Lo	cation					Od. Inside C	
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	the h	Director	MD 10e. Street and Number	Howard	1		Laurel	10f. Zip Code			10g. Citizan of V	What Coun		
	3a or		8798 Doves	Fly Wa	ay			2072	23		USA			
20	15-0020 72 hours efter death with the Maryland *natural', or items 23s or 28s-f show edical Examinet must be notified at	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 Di		Armed F 1 X Yes If Yes, G	Forces? 2 🗍 No Bive	2 No 1 Yes 2 No Specify:				0- 14. Rac	e - Amano k, White, Wh:	etc.	
9	tural	Pa Da		ecedent's E	Year or	Dates:	18a Deced	ent's Usual Occu		16b. Kind of Bu	usiness/Inc	dustry		
Maryland 21215-0020	C	Completed	(Specify only Elementary/Secondery	highest gra	completed College	(1-4or 5+)		ent's Usual Occu kind of work done OO NOT use retire	during most of a	working	Wholesa Distrib	le L	Lquor	
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lan	s 1 and 2 should f Heelth end Men tem 27 is marks other traumatic		19a. Informant's Name/Re	elationship (Type, Print)		19b. Mailin	g Address (Stree	t and Number or	Rural Route Numi	oer, City or Town,	Stete, Zip	Code)	
			Sheri L. 01:	iver/V	Vife		8798	Doves 1	Fly Way,	Laurel,				
ore	Pages 1 an ment of Heel ant: If item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cren		Removal fron	n State	Placa of Dispos cemetery, cran	sition (Name of netory or other pla	ace)	Date	20c. Location -	City or To	wn, Stete	
Baltimore,	ment:		4 Donetion 5 □ O	ther (Specif	y)			Nationa		3/22/99	Arling	ton,	Virgi	inia
Bal	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleck Funeral Home Inc.											
	Physician	23a. Part 1. Erur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approxima Interval Be Onset and	ita etween Death
	/Medical		Immediate Cause (Final disease or condition		Mata	etatic	Renal (Carcinoma	2				1/2	Vasma
	Examiner		resulting In deeth)		a. Tie ca		(or as a conseq		2				2 1/2	Years
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B	death certifi e ettending ed for use es	Physician/M	Part II. Other algnificant of	onditions o	ontributing to	death but not re	esulting In the un	ndertvino cause o	ivan in Part I	23b. Dic	tobacco use co	ntributa to	the cause	of death?
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on	After fune	tion 1		Pending investigation	(Mo	onth, Day Year)	Injury	M 1	ork?]Yes 2□No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Division or Attending efter death. Director: After d in by the fune		Certification:		Could not b determined	e 28e. Pled	ce of Injury - At ding, etc. (Spec	home, farm, stre cify)	et, factory, offica			28f. Location (Street and Number or Rural Routa Number City or Town, State)			
	Hospital 24 hours Funeral stely filled	edical C	29a. Certifier 1 C (Check only 2 M	ertifying Ph edical Exar	niner: On tha	ne best of my kr basis of axamir inner stated.	nowledge, death nation and/or inv	occurred at the t restigation, in my	lme, date end plo opinion, death o	ace, and due to the ccurred at the time	ceuse(s) end me , date and pleca,	enner as s and due to	tated.	(8)
	within 2 To the comple	Me	29b. Signature and title of	cartifier				29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)	
V			1	M	1		1	חפים	5996		3/16/9	Q		
1		1	30 Name and address of	person who	completed car	use of death (Ite	em 23a) (Type,		,,,,,		2/10/9			
+1			Linda Burre	e11, M				k Drive	#210, S	ilver Sp	ring, MD	2090)2	
0	Sta	te	31. Date filed (Month, Pay	q'q"')		Registrar's Sig		ake						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth Month SHIRLEY ANN PROPST MARCH 7:40 AM 1999 15 4c. County of Deeth 4a Facility Nama (If not institution, give street and number, 4b. City, Town, or Location of Death GEN BURNIE 7. Age (In yrs. lest birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Months | Davs | Hours | Min. | 8. Dete of Birth (Month, Day, Year) ARUNDEL ARUNDEL 5. Social Security Number Birthplece (State or Foreign Country) Days 1□ M 2Q+F 63 219-30-1062 July 03 1935 Maryland Usuet Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Md. 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21230 802 E. Fort Ave. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give A Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home Owner 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Mary Miller Edward Johnson 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Dale Propst, Sr. (Husband) 802 E. Fort Ave. Baltimore, Md. 21230 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Memorial Pk. 3/19/99 Glen Burnie, Md. 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility McCully-Polyniak Funeral Home P.A. 6 130 E. Fort Ave. Baltimore, Md. 21230 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause or each line. Approximete Interval Between Onset end Deeth Immediate Cause (Fine RESPIRATORY FAILURE Due to (or as e consequence of): diseese or condition resulting in death) CONGESTIVE HEART FAILURE (End Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown CEREBROVASCULAR ACCIDENTS (STROKE 24b. Were autopsy findings aveilable prior to completion of causa of death? 24a. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 1; Netural 2 Accident

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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worle !

r than "natural", or items 23s or 28s-f shore the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Hasith and Mental Hygiene. Important: If Item 27 is marked other than "nature!! any Injury or other treumstic excessions."

Examiner physicien and the buriel-transit been signed by the a should be datached f

The lew requires that the death certificate be executed

P.O. Box 68760

Division of Vitai Records.

Physician/Medical à Completed funeral director, Be Certification: To After this

Medical

n Hospital or Attendin n 24 hours after death. P Funerel Director: Aft filled in by completely within 2 ş

or Attending Physician:

SAJID 31. Dala filed (Month, Day, Year) State MAR 1 6 1999 Registrar

30. Name and add

3 Suicide

4 Homicide



of person who completed cause of deeth (Item 23a) (Type, Print)

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

NORTH

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.

29c. License number

1)51245

1 Yes 2 No

iner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

ARUNDEL HOSPITAL - M!

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MARCH 15,1999

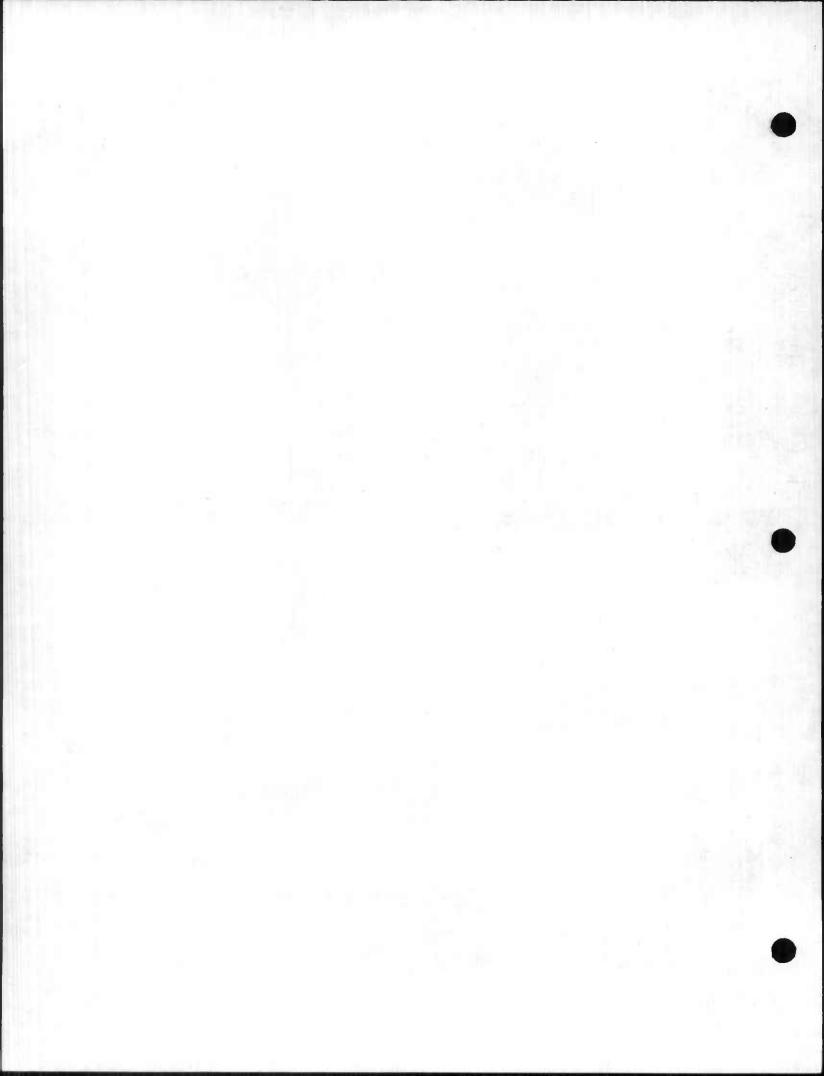
296. Signature and title of certifier

5 Pending investigation

6 Could not be

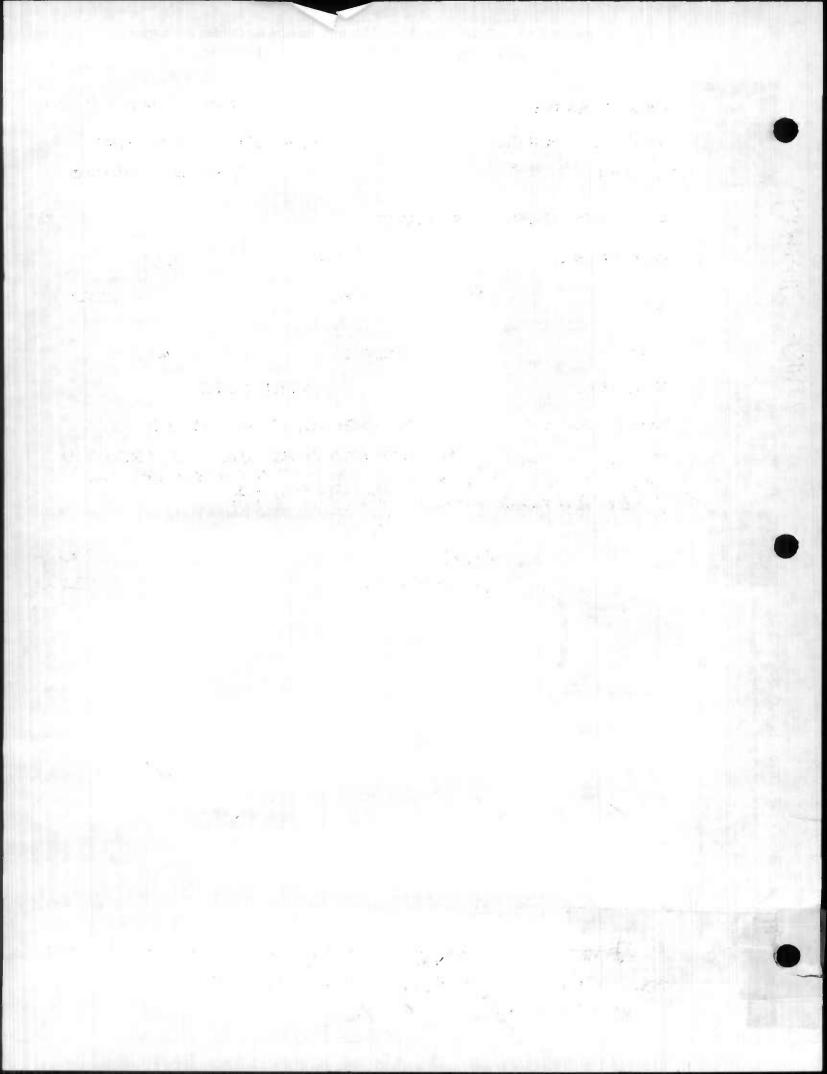
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GEORGE	CHANEY	()						WARFIE	lle, Malden Su L D	mama)			
19e. Informent's N	Neme/Relationship	(Type, Print)		19b. Mailing	Address (S	Street and Num	ber or Rur	al Route Num	ber, City or T	own, Stata	a, Zip Cod	(e)	
LORIE	PFANNENST	EIN		10959	HARME	L DR.	COLU	MBIA.	MD 210	44			
20a. Method of Dis	•	Dam aval from		Plece of Disposi	ition (Neme	of er plece)		Data	20c. Local	tion - City			
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21. Signature 1	arel Service Light	Gubo	1	22.	Name end A	Address of Fed	cility FI	NK FUN	ERAL HO	OME,	P.A.		
KFF	426 CRAIN HWY., S.W.												
23a. Part1, Enter shock, or he	the disease, of con	blications thet	caused the deet	h De set set	T-1-14								
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State of Maryland / Department of Health and Mental Hygiene

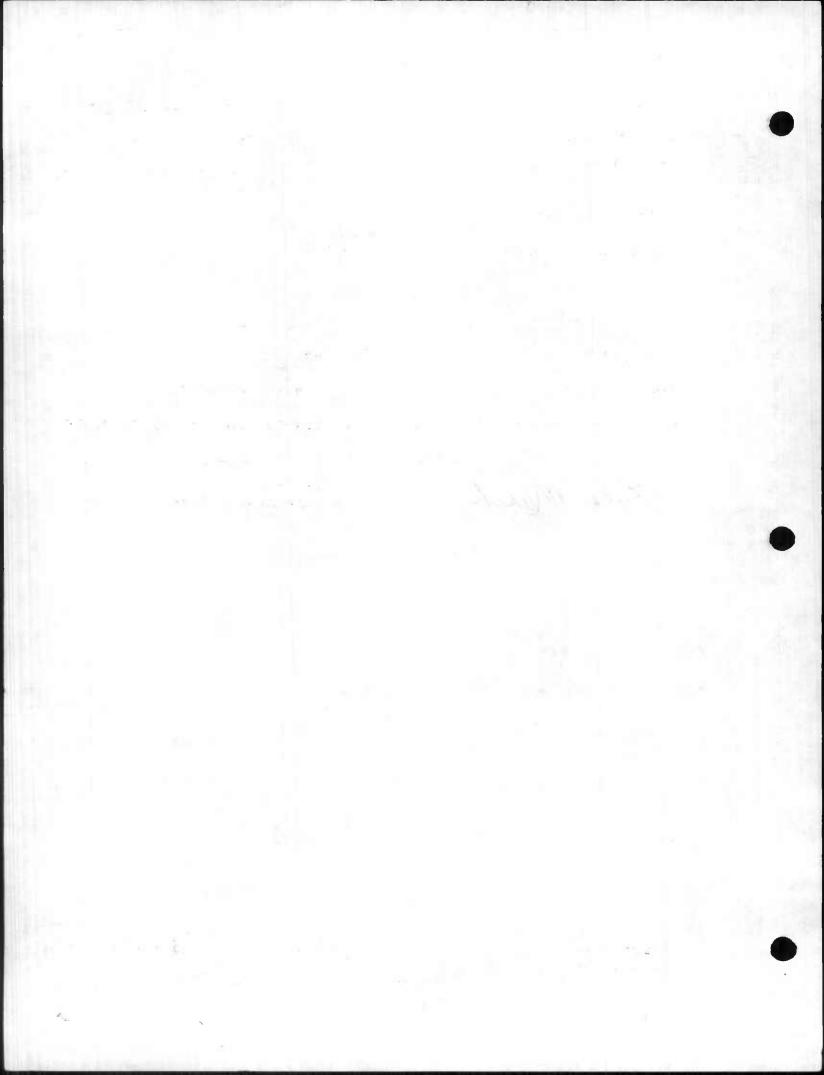
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			30. Name end address of person who completed causa of death (Itam 23a) (Type, Print) Deborah I PIENCE 1220 Park Height	ts Aver				78
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Lillie Patterson 3 1999 4:20 P.M. 11 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3222 Burleigh Avenue Baltimore N/A 5. Social Security Number 042-12-1306 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) 8. Dete of Birth (Month, Day, Year) Funeral Days Months Hours 1 M XCX Director 81 5-03-1917 S.C Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Md N/A Baltimore 1 ¥ Yes 2 □ No Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 9 3222 Burleigh Avenue 21215 USA "naturel", or flems 23s Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural" — any injury or other traumatic averages. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: Black à 3 Widowed 4 Divorced Yeer or Detes Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry City of Baltimore Elementary/Secondery (0-12) College (1-4or 5+) 12th grade Masters Liberian 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alexander Patterson Mariah Robinson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Houston, 3222 Burleigh Avenue Balto, Md 21215 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Elliot Cemetery 3-20-99 Hilton Head Island, S.C 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Fuperal Service Licenses 4300 Wabash Avenue Balto, Md 21215 23a-Fert1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical METASTATIC BRAST CENCEN. Immediete Cause (Final diseese or condition resulting in deeth) Examiner Examiner that the death certificate be assecuted physician and s the burial-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown bengis d be det Division of Vital Records, à The law requires 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? Deed page 2 s 20 No 1 Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 1 Neturel 2 ☐ Accident 5 Pending investigation death. 1 Yes 2 No Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 124 hours after die Funeral Direct oletely filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) 118320 30. Name and address of purron who completed cause of deeth (Item 23e) (Type, Print) John Tetto Bethrom 70 21287. ns CLOKA Johns Hopkins DNODES 31. Dete filed (Month, Dey, Year) 2. Registrar's Signature State MAR 1 6

Registrar **DHMH 16 Rev 6/95**



Physician /Medical Examiner physiclan end s the burial-transit

Physician

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Funeral

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permit. Pages 1 and 2 should be filed within 7 Department of Health end Mental Hygiena. Important: If flem 27 is marked other than "na any titury or other traumatic event other."

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death

Examiner

2 Accident

3 Suicide

29a. Certifler

4 Homicide

(Check only one)

29b. Signeture and title of certifler

Physician/Medical been signed by the should be detached þ Completed 2 this funeral Certification: After

P.O. Division of Vital death. To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A complately filled in by the fu

State Registrar

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140 CODRUBETZ 31. Data filed (Month, Dey, Year) MAR 1 6 1999 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

invastigation

6 Could not be determined

25DI Old Annuayoles Rd Ellict Cly MD

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

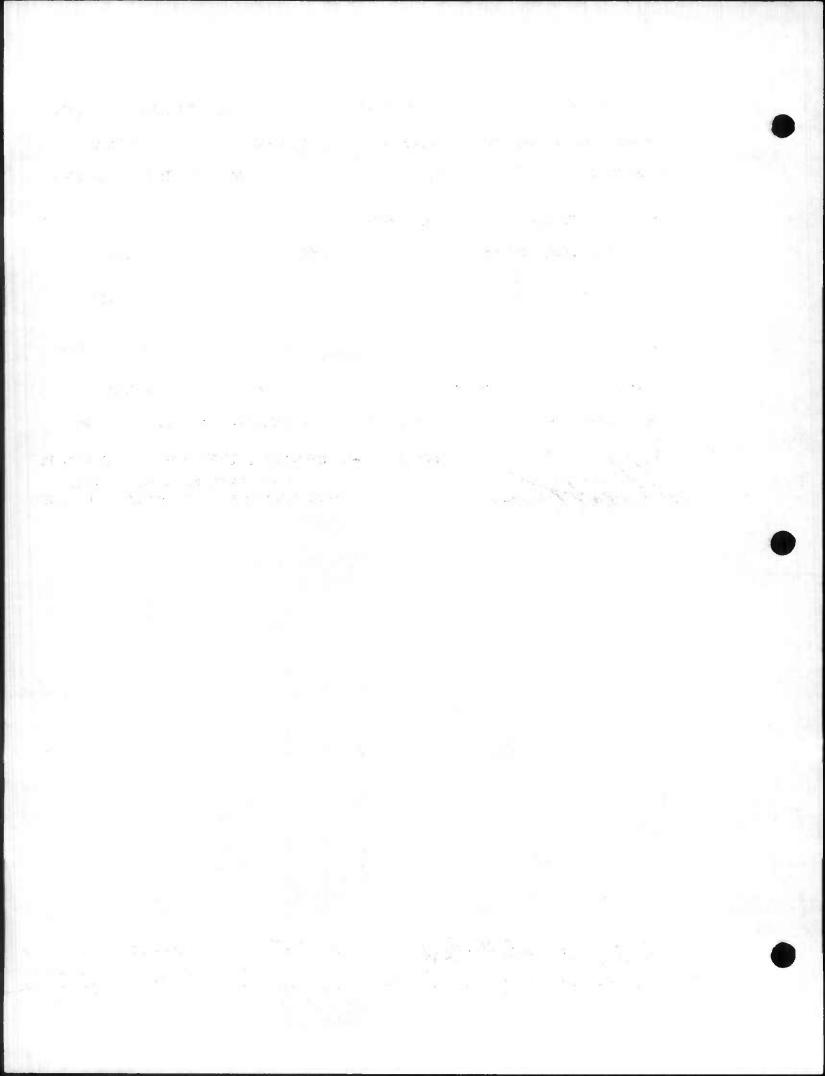
29d. Dete signed (Month, Dey, Year)

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Certifying Physician: To tha best of my knowledge, daeth occurred et the time, dete end plece, and dua to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated.

29c. License number



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Year Physician THOMAS QUEEN 11:03 PM MARCH 1999 12 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Death Examiner UNIVERSITY OF MARY LAND MEDIUM SYSTEMS BAUTMORE N/A If Under 1 Yaer If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 1XM 2□ F Vre Director 218-46-9140 50 Oct. 20,1948 Maryland Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 'natural', or items 23s 2812 Florida Avenue 21227 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - American Indian Black, Whita, atc. hours after 1 Nevar Marriad 2 Merried 1 ☐ Yes 2 ☒ No If Yas, Give Yaar or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 ♥ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry i Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 Repair Mechanic 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental: Hy
Important: If them 27 is marked other
any injury or other traumatic event Be Unknown Betty Herd 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Rose M. Queen / Wife 2812 Florida Avenue, Baltimore, Maryland 21227 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Cedar Hill Cemetery 3/17/99 Brooklyn Park, Maryland 22. Nama and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceusa (Finel disaasa or condition rasulting in deeth) /Medical DERSIS - OVERWHELMING BAUTKIM INFECTION Examiner Due to (or as a consequence of) HON HODULINS LYMPHOMA attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immadiata cause. Entar Underlying Cause (Disease or injury Dua to (or as a consequence of): P.O. Box 68760 Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown been signed Records, by 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Completed performed? page 2 2 0 No 1 Yas 1□ Yes 20 No certificate Division of Vital Physician: director, Be 25. Wes casa rafarred to medical 26. Place of Death (Check only one) examinar? Hospital: 1 🖄 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Mannar of Death Data of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Physicial 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 5 Panding investigation 1 Natural Injury 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifie (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Marz 12477 collus DEN 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) RUBENFELD 9738 Courtey MEADOWN VANE - # 13

State Registrar

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31. Data filed (Month, Day, Year)

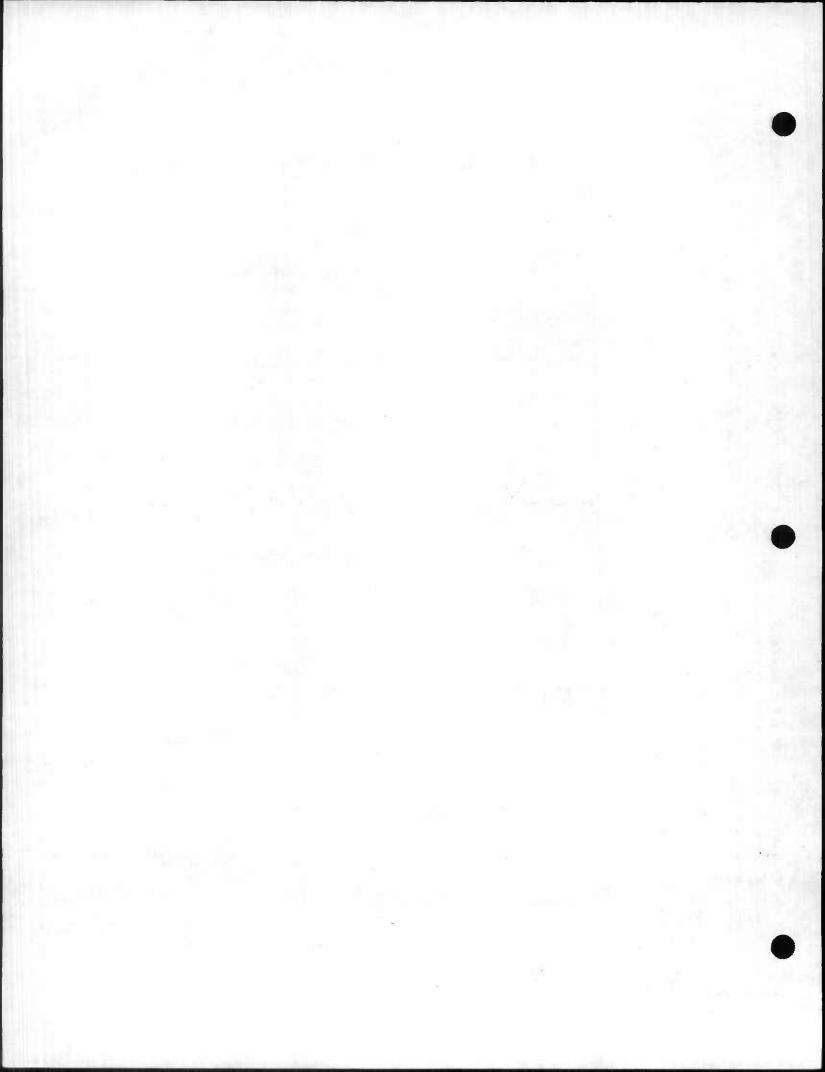
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32. Registrar's Signature

(AULER, MO 20723



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Gertrude Verna March 14, 1999 8:00 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Of Hammonds Lane Baltimore Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) **Funeral** Min. 10 M 20 F Days Hours Months 217-32-7567 90 Director June 26, 1909 | Maryland Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ♥ Yas 2 No Director 28a-f Md. N/A Baltimore 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be r deeth with 3550 Horton Avenue 21225 U.S.A. Funeral Herra 2 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filled within 72 hours after d nant of Health and Mental Hyglena. ant: If Nem 27 is marked other than "natural", or Itan ury or other traumatic event, the Medical Examinal. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: þ 3 Ø Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th Collega (1-4or 5+) 0 Homemaker Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) B John Wolf Gertrude Otto 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 Gordon Court Glen Burnje, Maryland 21061 Catherine Schmidt (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1) Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Department of Important: If any injury or page. Moreland Memorial Park 3/17/99 Baltimore, Maryland 21. Signature of Funeral Sarvice Licensee McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Arry Amin Immediata Causa (Final disease or condition resulting in death) /Medical 30 min Examiner Dua to (or as a consequence of):

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Dua to (or as a consequence of):

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Dua to (or as a consequence of):

Congestino heart failure Examiner anding physicien and use as the burial-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. Physician/Medical signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 Yes 2 No 1 Yas 2 No certificate Physician: director, 8 25. Was casa refarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To sin funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural or Attending 5 Pending invastigation i Director: Aft od in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funerei D completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of complier Zunland MA 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Dr. Silvino Muneses 3721 Potee Street Baltimore, Maryland 21225

Registrar

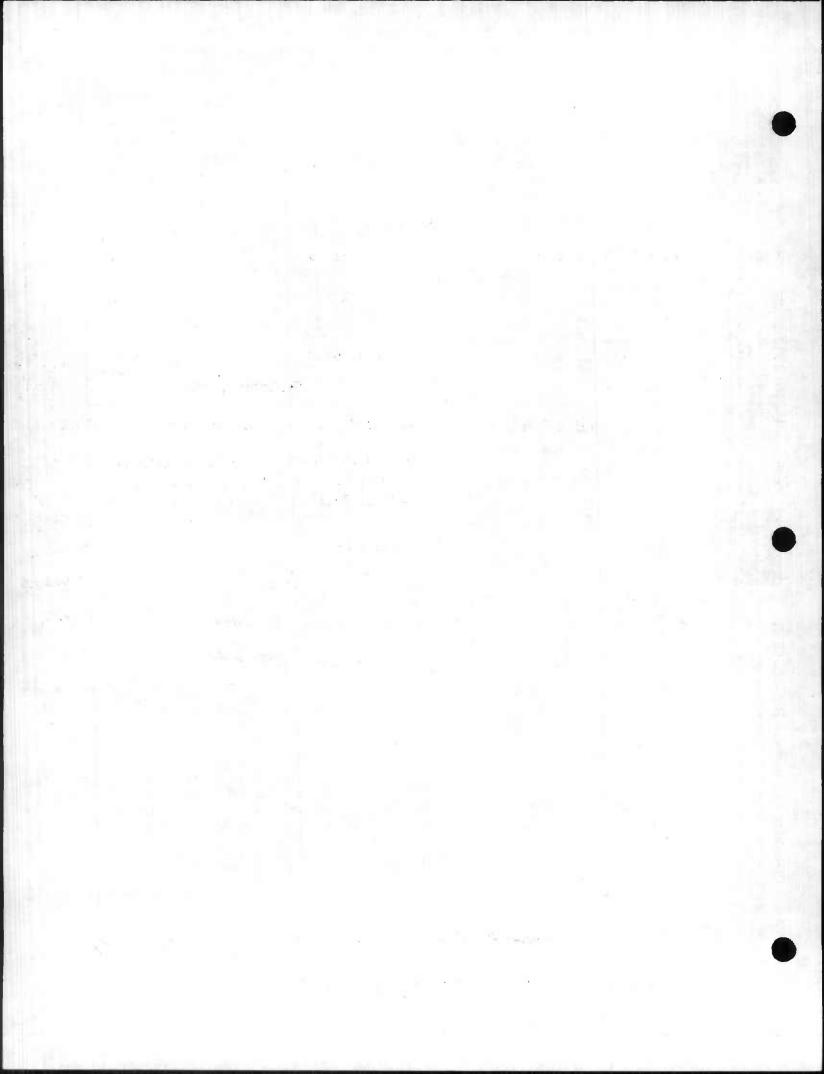
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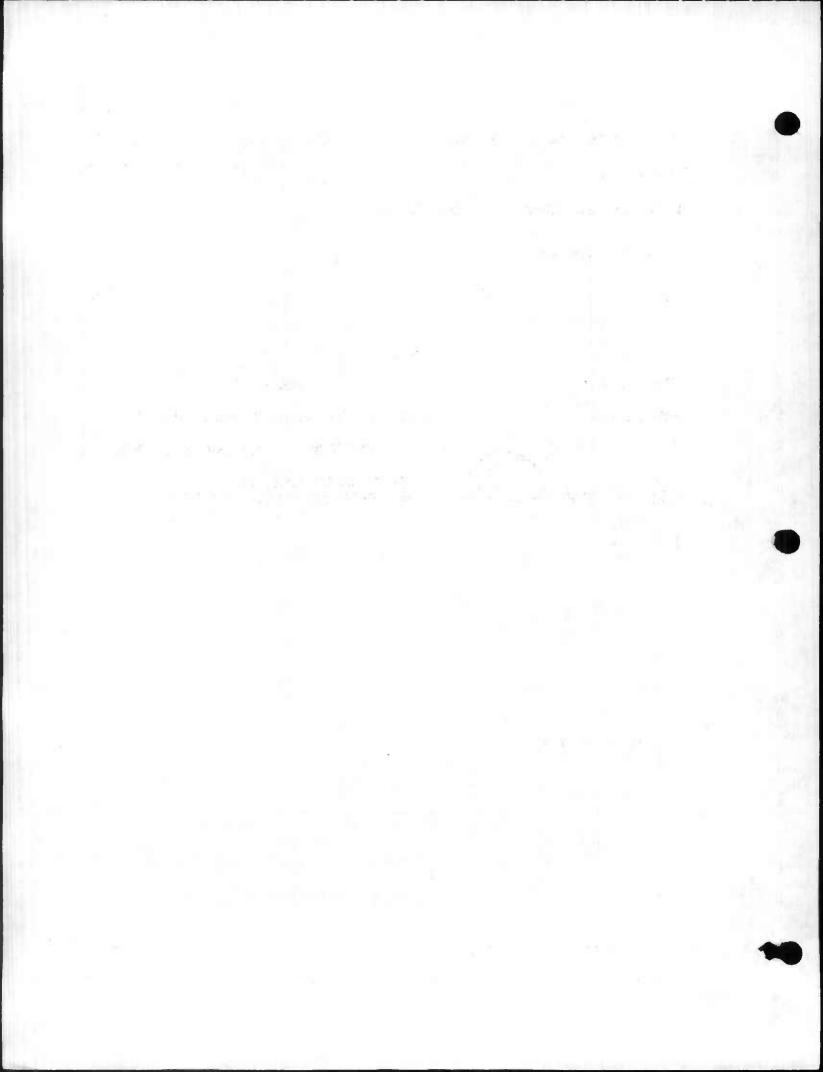
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32. Registrar's Signature



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Herra 23a or 28a-f show ner must be notified at	tor	10a. State 10b. County MARY LAND ANNE ARI		VERNA PA					10	Od. Inside City Limits
or 28a	Director	10e. Street and Number		-	10f. Zip Code		10	Og. Citizen of	What Count	try?
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To th		29b. Signeture and title of certifier			29c. Licens	e number		d. Date signe		
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1	3	0. Neme and eddress of person who com	pleted cause of death (Item	n 23a) (Type, Pr	int)	sover s				-
	-	SURYA MUND	RA MO	3001	0 110 a	milian C	1 RA	17, M.	0 F 1	(M) 2121



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Yaar **Physician** ichter 95 Kurt 99 11 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anuvdel Burnie North HOSPITAL o PN (If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 11/23/1930 Social Security Number 9. Birthplaca (Stata or Foraign **Funeral** Days XXM 2 F Hours EAST GERMANY 217-38-5535 68 Director Usual Rasidanca of Dacedan 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Herre 23a or 28a-f shov iner must be notified at 1 Yes XX No Directo ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 602 DOGWOOD DRIVE U.S.A. 14. Race -Funeral 21061 12. Was Decedent Ever in U.S. Armed Forces? 1 [] Yes 2 [] XX If Yes, Give Year or Dates. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black White atc. than "natural", or item the Medical Examiner 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes WNo Specify: Specify: Àq WHITE 3 □ Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) Callege (1-4or 5+) 12 CARPENTER MD. DEPT. OF CORRECT. 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Be h and Mental I and 2 should be RICHARD RICHTER FRIEDA HEIDEMANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ant: If Item 27 is 602 DOGWOOD DRIVE, GLEN BURNIE, MD 21061 ERIKA RICHTER - WIFE aftimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition 20c. Location - City or Town, State 1XXurial 2 Cremation 3 Removal from State DEICHGRAUBER FAM. CEM. 3/16 SEVERN. MARYLAND Other (Specify Fineral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME, P.A. KELLY GREGORY 426 CRAIN HWY. S.W. FINK GLEN BURNTE, MD 21061 There the mode of dying, such as cardiac or respiratory arrest, art. Enter the comme, or complications that caused the death. Do not ente Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ulvutes disease or condition resulting in daath) Examiner Examiner nterioscleratio physician and s the burial-tran Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be exec Physician/Medical Dua to (or as a consequence of): USB BS 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peeu page 2 1 Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital 25. Was case raferred to medical Be 26. Place of Death (Check only one) ninar? Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yes 2□ No 2 this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Panding investigation Natural Hospital or Attending 24 hours after death. Funeral Director: Aft 1 Yes 2 Accident 3 Sulcida 6 Could not be datarminad 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, date and place, and due to tha causa(s) and mannar as stated. 2 Medical Examiner: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner stated. edicai 29a. Cartifian To the Within 2 To the

State Registrar

31. Date tiled (Month, Day, Year) 1 6 1999

29b. Signatura and titla of certifiar

32. Registrar's Signature

JONES, MO

ne and address of person who completed causa of daath (Item 23a) (Type, Print)

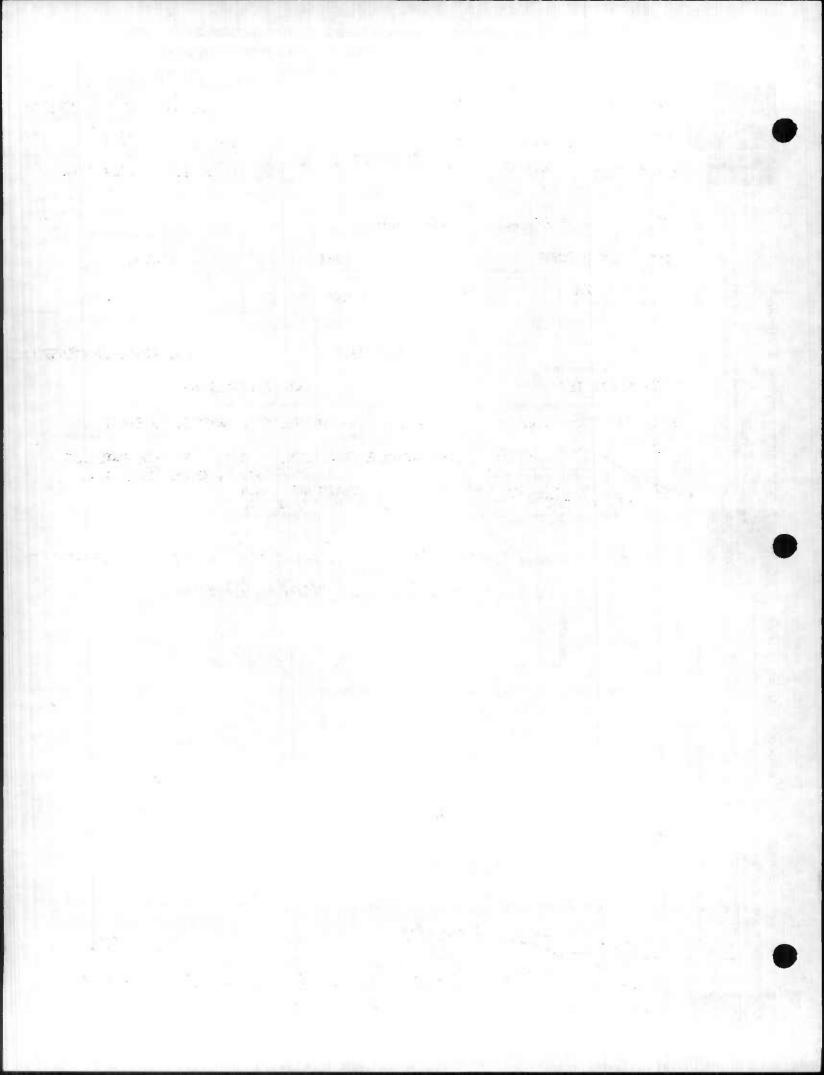
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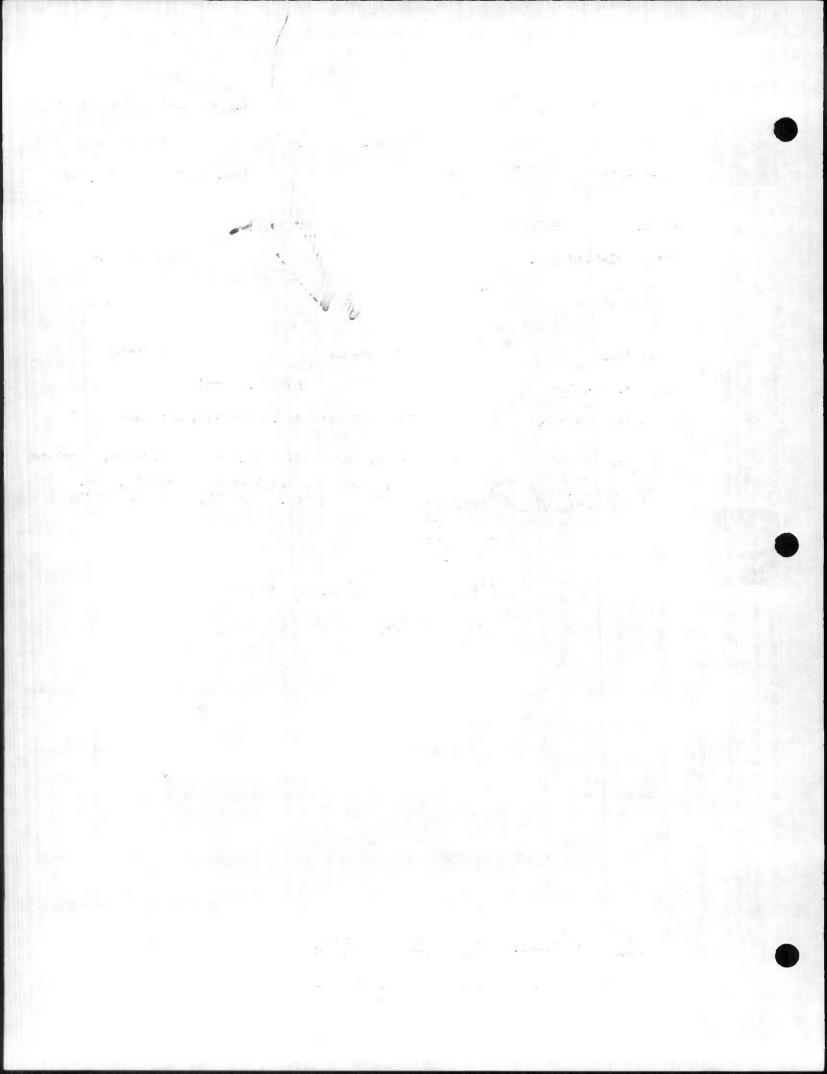
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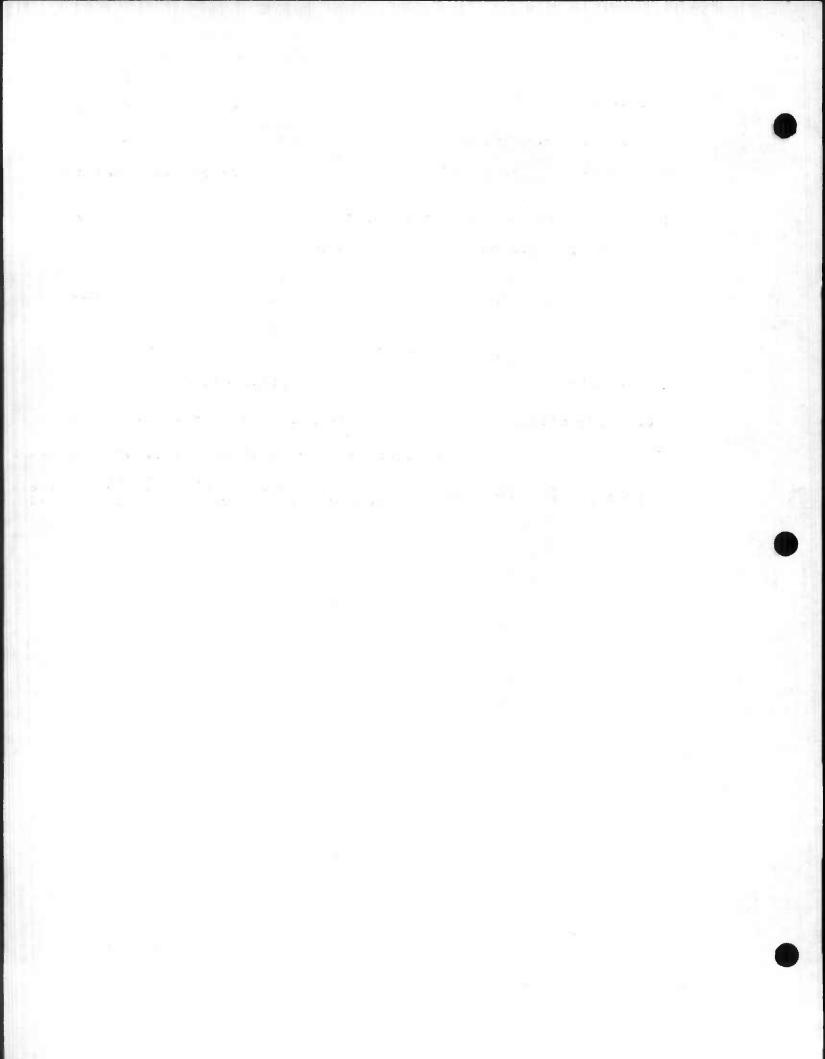


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State of Maryland / Department of Health and Mental Hygiene

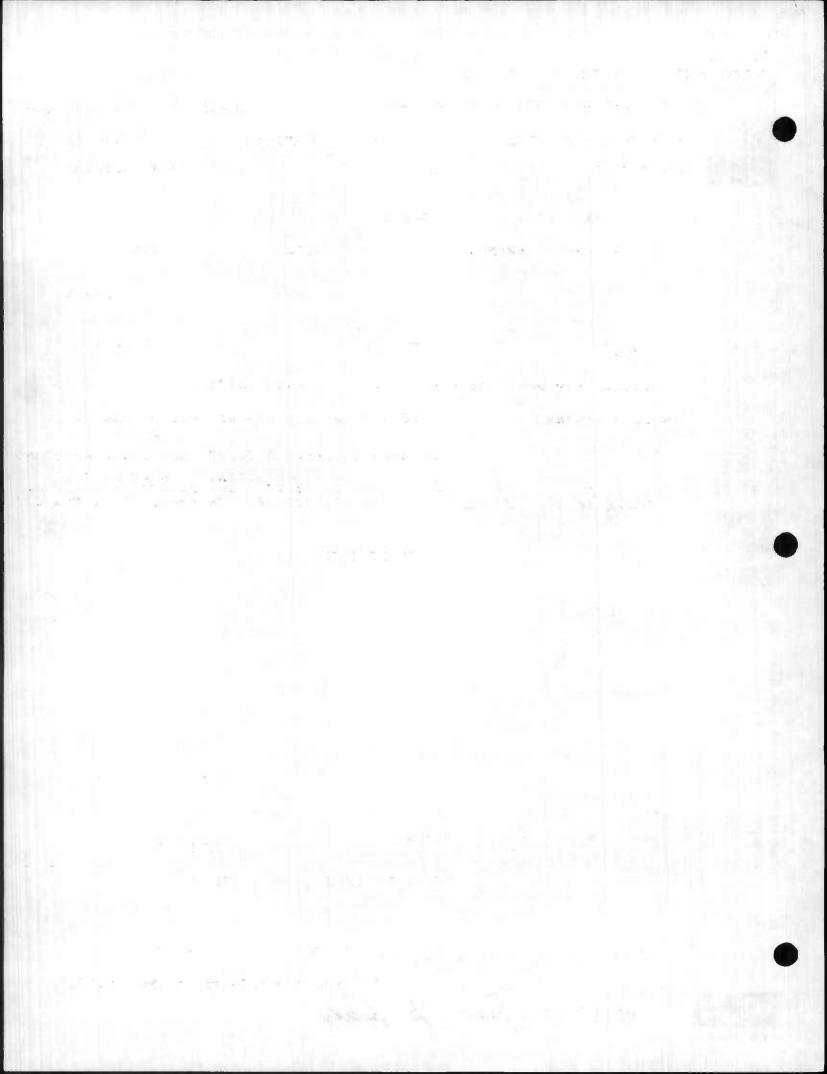
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Physician /Medical	ı	YVONNE RAY								Month MARCH	Dey	1999 1999	2:30A	
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Funeral Director		5. Social Security Number 2 1 4 - 5 6 - 4 9 9 0	6. Sax		Age (In yrs. 47	last birthday) Yrs.	If Unda Months	ar 1 Yaar Deys	If Undar 24 Hrs. Hours Min.		th y, Year) 1951		place (State or Formatry) yland	eign
M	-	Jsual Residence of Decedent Oa. Stete 10b. County			10c. Ci	ly, Town or Lo	cation						10d. Inside City Lin	nits
le merked other than "netural", or itsme 23e or 28e-f show reumatic event, fre Medical Examiner must be notified at To Be Completed by Funeral Director		MD	N/A			BALTI	MOR	E					12 Yes 2 □	
riner naunt be notified Funeral Director	1	0e. Street and Number 422 WHITRID	GE	AVENUE			10f. Z	ip Code 21	218		10g. Citizen of What Country? $U \cdot S \cdot A \cdot$			
the Medical Examiner must be notified at ompleted by Funeral Director		1. Marital Status 1 Never Merried 2 Mer 3 Widowed 4 WiDivorced	rled	Was Deceda Armed Force 1 Yas 2 If Yes, Give Yaar or Data	s? XINo			edent of Hecify Cub	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yas or No Rican, etc.)		Race - Ameri Bleck, White pecify: B		
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or traumatic	-	19e. Informent's Ne <i>me</i> /Reletions Antionette							end Number or Ave					
iry or othe	2	Oa. Method of Disposition 1 🔀 Burial 2 🗆 Cremetion 4 🗆 Donetlon 5 🗀 Other (S		novel from Sta		Plece of Dispos cemetery, crem t. Zic	notoni or	other nie	ery 3/	Dete 17/99		tion - City or T i more	own, State , Maryl	and
Important: If Item 27 is any injury or other traughts.	2	21. Signature of Funerel Sarvice	Licensee	How	HIL		ERO	Y O		& SON	FUNE	RAL H	JR. OME, P. O., MD21	
physician and imposition is the buriel-transit and imposition in a particular	1	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to immediate	e b. =		Due to (d	AIDS or es e consequences e conseque	C					1	Onset and Deeth	
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neral director.		25. Wes case referred to medical exeminer? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 D 27. Menner of Deeth 1 Neturel 5 Pending Investigation Investigation 28e. Dete of Injury (Month, Day Year) Month, Day Year) M					26. Place of Deeth (Check only one) DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No			fy)				
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comp	2	9b. Signatura and titla of certifie	1				29		e number			igned (Month,	Day, Year)	
	3	0. Name and address of person KNESAIM Jeo	who comp	pleted cause of	death (Item	1 23e) (Type, I	Print)	nole	s st Bal	hmac m	9112 (14	230		
State Registrar	3	1. Date filed (Month, Day, Year)	1000		strer's Signa									



	LIAM INSON	ITEMS: #23 PART I,		F PER M	E0 G769	Cen	rificate d	of De	ath			U	5241
	hysician /Medical	1. Decedent's Name (First, Mide WILLIAM LA		ROBI	NSON,	JR .	•			2. Dete of Dee Month MARCH	Dey	Year 999	3. Time of Death 10:30P.M.
	Examiner	4e Fecility Neme (If not institution JOHNS HOPKINS							ity, Town, or Lo ALTIMOR	ocation of Deeth	4c. County	of Deeth	
	uneral rector	5. Sociel Security Number 2 1 9 - 6 6 - 5 3 9 3	6. Sex 12 M 2	7. Age	(In yrs. lest b	irthday)_ Yrs.	If Under 1 Ye Months De	ear If t	Under 24 Hrs. ours Min.	8. Date of Birth	1°9'58	9. Birthol	eca (Stete or Foreign
D		Usuel Residenca of Decedent 10e, Stete 10b, Count	4		10c. City, Tox	wo or Loc	ation					1/	d. Inside City Limits
Meryle	Teho For	E11, 7, 10:10	, TIMORE			SSEX						, ,	1 ☐ Yes 2 🛣 No
th the	r items 23a or 25a-fe niner must be notified Funeral Director	10e. Street end Number					10f. Zip Cod		0.03	1	log. Citizen of		lry?
ath w	aral I	1053 S. MAI				40.14	Donator		221			S.A.	an Indian
5-0020 72 hours efter death with the Merylend	er, or hem Examiner: by Fund	11. Maritel Stetus 12 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 T	es Decedent Ened Forces? Yes 271 Notes, Give er or Detes:			Yes, specify (exican, Puerto	ecify Yes or No- Rican, etc.)	Specif	ca - America ck, White, e y: B.	
d 21215-0020 filed within 72 hours eff Hygiena.	7 is marked other than *naturel; or items 23s or 28s-1 show traumatic event, the Medical Examiner must be notified at a completed by Funeral Director	15. Decede (Specify only high Etementary/Secondery (0-12) 1 0 t h	-	eleted) ltege (1-4or 5		e. Decede (Give k life. De Un k n	ent's Usuel Oci ind of work do O NOT use re O W N	cupation ne during tired)	g most of work	ing	16b. Kind of B	usiness/Ind	
Maryland 2 d 2 should be filed the and Mental Hygi	atic event, To Be C	17. Fether's Neme (First, Middle William La		e Rob	inson	, Sr	•			e (First, Middle, Goldman		ne)	
and 2 sho	traum traum	19e. Informent's Name/Relation Mary Robins		int)						el Route Numbe enue, E			
0 - ±	nt: If hem 27 ry or other	20e. Method of Disposition 1 28uriel 2 Cremetion 4 Donetion 5 Other (ol from State	20b. Pleca cemete Mt.	erv. cremi	ition (Neme o etory or other on Cem	plece)	ry 3/1		20c. Location Balti		wn, Stete , Maryland
Balt Permit.	Important: If it and it is a second of its and it is a second of its and its a	21. Signature of Fünerel Service 23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications	s that caused se on each lin	ne.	LE 46 not ente	ROY O	BER dying, su	TY HE	S SON I	VE.,B	L HOI	JR • ME , P • A • • , MD 2 1 2 0 3 Approximate Intervet Between Onsef end Death
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	attending physician end for use as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Lest	c		Due to (or es e								
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of Vital	rector, pag rector, pag	25. Wes case referred to medic exeminer? ↑\$\int_{\text{X}}\text{Yes} 2 \sum \text{No}	Hospite	l: 4 🗆 lanatia	-/ OFFED/6	No object and a set	2004	Other:		th (Check only of		nas (Canaih	4)
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Div To the Hospital or A within 24 hours effar	To the Funeral Director: After completely filled in by the fune Medical Certification	(Check only 2 Medica	ng Physician: I Examiner: Or	To the best of	FOUN f my knowledg examination a	ND AT	RESIDENI	CE e time, d	ate end place,	BALTIMORE end due to the d red et the time, of	, Md.	enner es st	eted.
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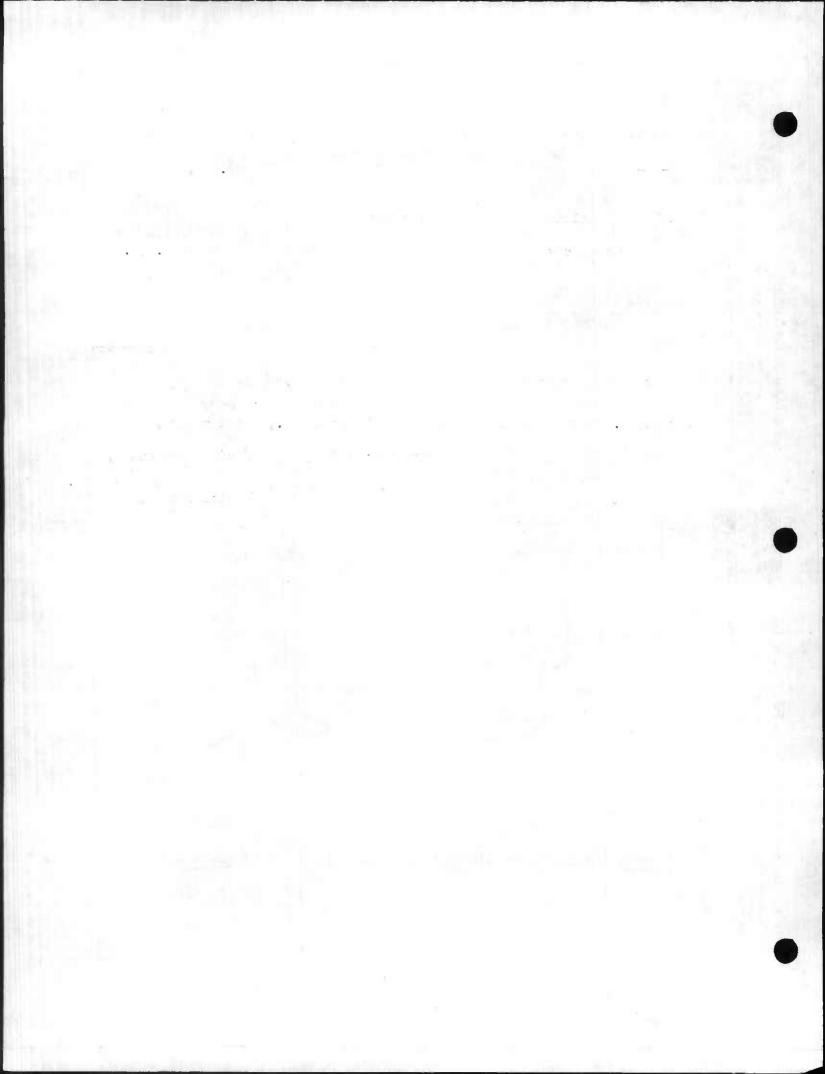
Registrar

MAR 1 6 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

_								ertificate of			No. 9	U	8242	
	Physicia /Medica	_	1. Decedent's Nam ANN	e (First, Middle, La SWART	ist)					2. Date of Death Month	Day 15,	Year 1969	3. Time of Death	
0	Examine		4e Facility Neme (I Carroll	f not institution, giv County Ge	eneral	umber) Hospital	1		4b. City, Town, or Westmins	Location of Death	4c. County Carr			
3	Funeral Director		5. Sociel Security N 347-10-01	98	Sex 1□M 2 □F	7. Age (In yrs. 91	last birthd Yrs	Months Day			1 907	9. Birthple Count	ace (State or Foreign ry) Germany	
. 3	2		Usuel Residence of 10a. Stete	Decedent 10b. County		10c. Cit	Location			10	d. Inside City Limits			
	the Maryta 288-4 shon notified at										1 ☐ Yes 2 No			
_	6 8 8	al Director	10e. Street and Nur 105 Gly	mber ndon Driv	ve .			10f. Zip Code	1136	109	U.S.		137	
) Jule 1020	Maryland 21215-0020 d 2 should be filed within 72 hours after death with and Mental Hygiere. 77 is marked other than "natural", or liente 23s traumatic event, the Medical Examiner must		11. Maritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Wes Dece Armed For 1 Yes, Giv. Year or De			orees? 2⊟ No ive	No 1□ Yes 21 No			Specify Yes or No- rto Rican, etc.)	14. Race - American Indian Black, White, etc. Specify: White		ic.	
5.03	72 ho natur disal.	eted	(Spec	15. Decedent's Enify only highest gra	ducation ade completed)	16a. De	cedent's Usual Occ ive kind of work don e. DO NOT use reti	upation e during most of w	orking 16	b. Kind of Bu	siness/Ind	ustry	
121	Den Com	Completed	Elementary/Seco			(1-4or 5+)	· life	e. DO NOT use retii	red)		Groce	rv St	ore	
9			17. Father's Name	(First, Middle, Last)			OTCIN	18. Mother's Na	me (First, Middle, Ma				
a	thould be ut Mental marked o matic eve	To Be		osenberge					Henrie	etta				
ary	2 shou and M is man sumst	-	19e. Informent's No	eme/Reletionship (Type, Print)		19b. M	ailing Address (Stre	et and Number or F	Rural Route Number, C	ity or Town,	State, Zip	Code)	
2	es 1 and 2 of Health of them 27 to r other tra		Bernice C	. Swart	Daught				ale Rd.,	Reistersto	own, M	D 211	36	
Baltimore,				osition ACremetion 3 D 5 Other (Specif		State	cemetery, o	sposition (Name of cremetory or other p 1 Cremati	lace) OIl		c. Location - lampst			
Balt	Department Department Important: I any Injury o		21. Signature of Fu	neral Service Lice	la	0		22. Neme and Add Eline Fu	ress of Fecility neral Hor	ne 11824 Re Reisters			Rd. 21136	
			23a. Pert1. Enter the	ne disease, or com	plications that	caused the deat	h. Do not	enter the mode of d	ying, such es cardia	ac or respiratory errest			Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (disease or condition resulting in death)	Finel	· Ma	125/2	tic	Carcinon		the Bre			Onset end Death	
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u .	Wher th		27. Manner of Deati 1 ☑ Natural	5 Pending		of Injury oth, Day Year)	28b. Tim Inju	y W		28d. Describe how	injury occur	red		
Divisio	or Attending Physics after death. Director: After this in by the funeral	Certification:	2 Accident investigation M 1 Yes 2 No									et and Number or Rural Route Number, Stete)		
	2 1 1 0 C	edicai Ce	29e. Certifier (Check only one)		niner: On the b					e, and due to the caustured at the time, date				
	vithin To the	X X	29b. Signeture end	title of certifier	111	mb		29c. Lice	nse number	29d	Date signer	d (Month, L	Day, Year)	
5			30. Neme and address	ess of person who	completed cau	se of death (Item	n 23a) (Ty	pe, Print) (255 (la	At Drive	æ	isterst	our MD	
er -	State Registra		31. Dete filed (Mon	th, Dey, Year) 6 1999		Registrar's Signa	ature	Soa. V.						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Vear **Physician** Satchell Patricia 9:25 PM March 1999 /Medical H Under 1 Year If Under 24 Hrs. 8, Dete of Birth (Month, Dey, Year)
Hours Min. FG3. 8, 1960 4e. Fecility Neme (If,not institution, give street end number) 4c. County of Death **Examiner** Hopkins BAYVIEW LA 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplaca (Stete or Foreign Country) **Funeral** 1□M 28 F 2/6-84-248 Usual Residence of Decedent 39 Yrs. Director mary/po 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show Examiner must be notified at BALTIMORE Ves 2□No Director Harylmo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 6000 USA Yark Нета 23a MORAVIA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: 11. Maritel Status 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. Peges 1 end 2 should be filed within 72 hours after of tent of Heelth and Mental Hygiena. nt: If Item 27 is marked other than "natural", or Itei 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 20No p Black 3 ☐ Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry University Hospital Elementery/Secondary (0-12) College (1-4or 5+) Martuny Assistant 1248prs 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) . LADY ALICE KENION Strother GEOTGE 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2/3/7 19e. informent's Neme/Relationship (Type, Print) permit. Peges 1 end 2 s Depertment of Heelth ar Important: If Item 27 la any Injury or other trau ADY A. Strother-Winston BAK BALLINUE, 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Facility & HATMAN-5240 RUSTERSHOWN RAN 21. Signature of Sunerel Service Licensee Red or Ped. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate ervel Between Onset end Death **Physician** /Medical immediate Cause (Final neumococca disease or condition resulting in deeth) Examiner Meuhococcal burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? page 2 s 1 Yes 20 No certificata Division of Vital Hospital or Attending Physician: 24 hours aftar death.
Funeral Director: After this certificately filled in by the funeral director. Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral DI complately filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and menner stated. 29a. Certifler 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) Bayview Medical Center 4940 Eastern Avene, Baltimore, MD 21224 SCOTT ZAFT

Registrar

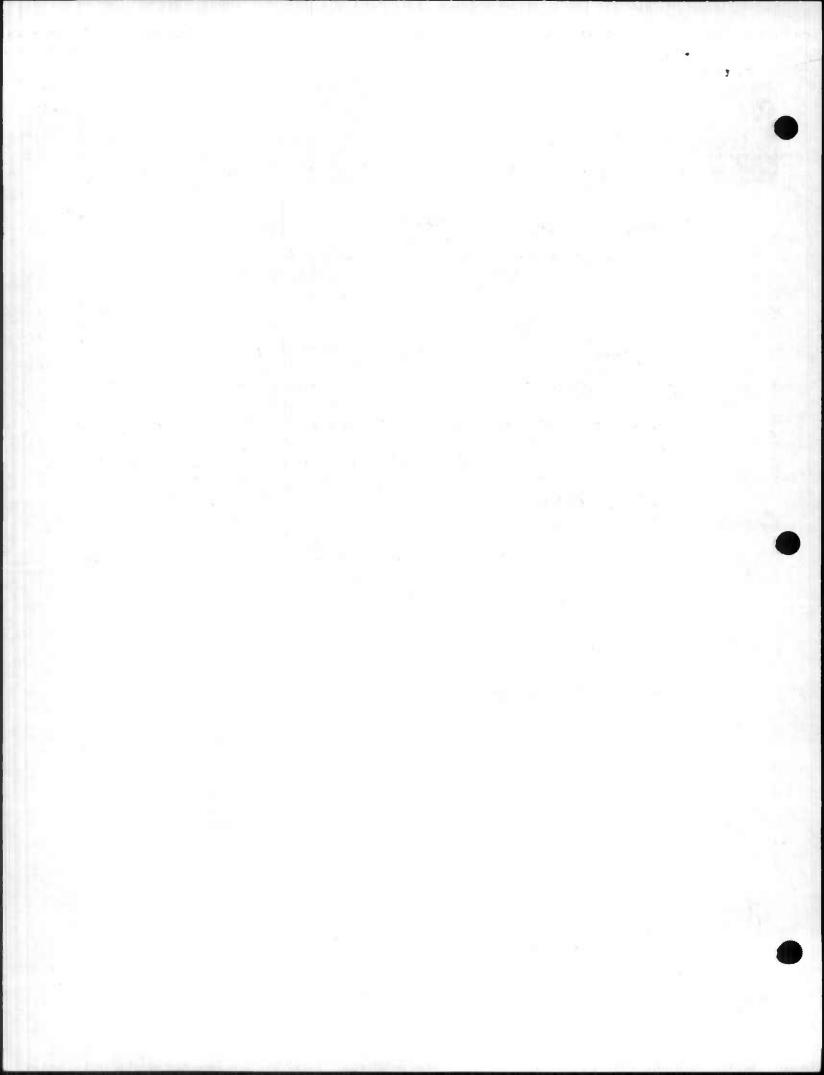
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State

31. Date filed (Month, Day, Yeer)

MAR 1 6 1999

32. Degistrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Data of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month 11: 40 AM ebecca March 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death G000 BAltiMORE SAMAritMU If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Days 219-12-6678 Yrs. Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits BOIHMORE Yes 2 No Hary Isus 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21206 4703 AUG RENWICK 14. Race - American Indian, Black, White, etc. 12. Was Dacedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 No Black 3 Widowed 4 Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2. P 18a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondery (0-12) Hospital College (1-4or 5+) arado 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Elickson CHARLES LIllian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ECNWICK AUE Baltonor, Mary lans ERNEST SPILE, SR Sun 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ANBUTUS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHA TOLON - A PATTIS 21. Signature of Funeral Sarvice Lightness 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Caldiagenic embolism Hulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Interstitial disease ung Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Ves 2□ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑ No 1 ☑ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred

Physician /Medical Examiner

Examiner

Physician/Medical

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Funeral

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Is marked other than "natural", or flems 23a or 28e-1 show traumatic avent, the Magical Examines must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiena. Important: If them 27 is marked other than "natural", or frems 23e any injury or other traumatic avent, the lawses

the Maryland

attending physician and for use as the burial-transit the a signed by peen s certificate has

The law requires that the death certificate be asscuted

P.O. Box 68760.

Division of Vital or Attending Physician: pheumonia

1 Natural

2 Accident

4 - Homicide

(Check only one)

3 Suicida

29a, Certifier

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, and due to the cause(s) and manner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. Licansa number P12558

29d. Date signed (Month, Day, Year) Merch

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Maral Donabedian. 5601

31. Date filed (Month, Day, Yeer)

MAR 16 1999



Loch Raven Ballevall, Ballimore, M.D. Oscal

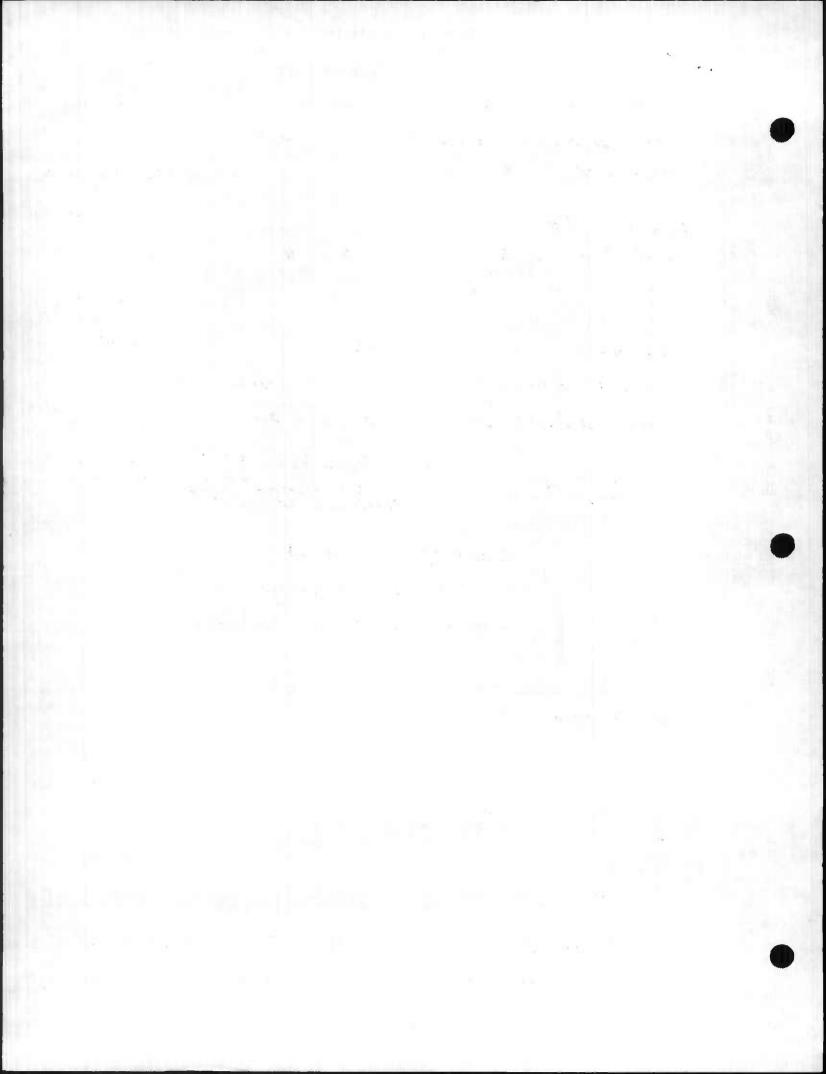
Registrar

DHMH 16 Rev 6/95

To the inception of the death.

Within 24 hours after death.

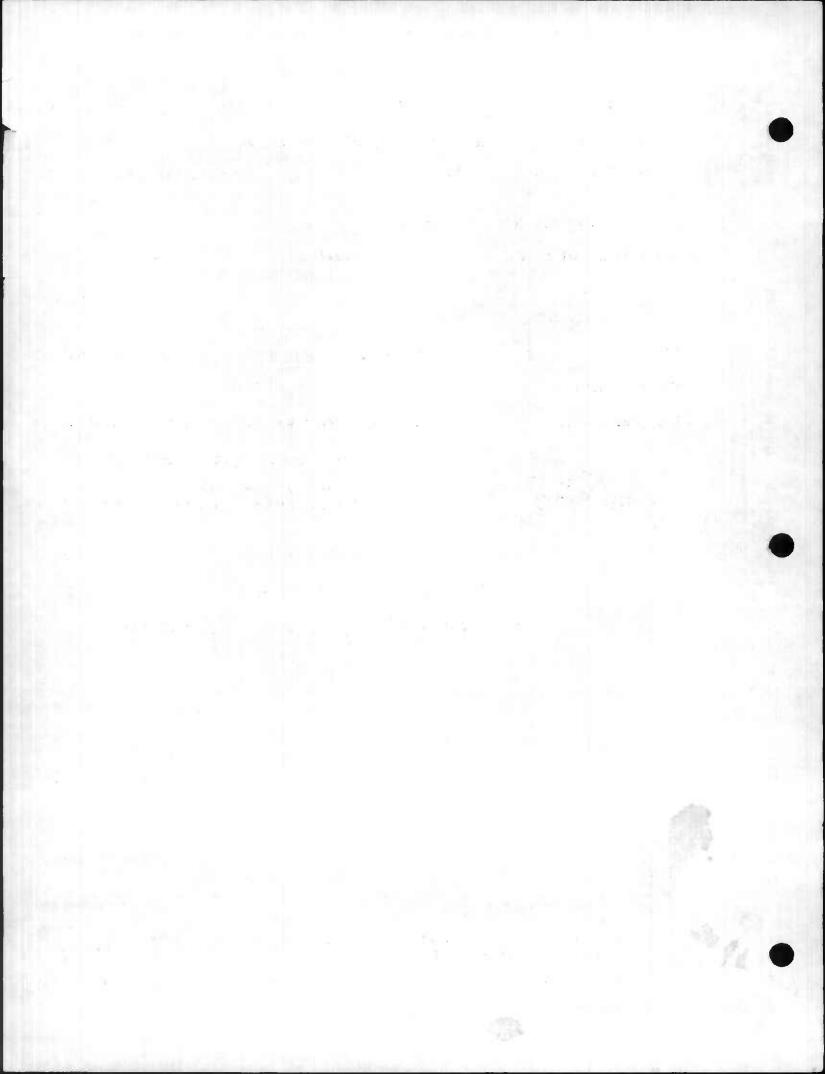
To the Funeral Director: After this in the funeral director of the funeral director.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month **Physician** 40 AM NOMAS MARCH /Medical Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SYSTEM BAHIMORE
If Under 24 Hrs. 8. Deta of Birth
Hours Min. (Month, Dey, Year) MARYLAND 04 MEDICAL If Undar 1 Year Months Deys 7. Age (In yrs. lest birthdey) Birthplaca (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** Deys 1₩ 2□ F 167-40-7545 51 Pennsylvania Director Aug. 14, 1947 Usuel Residence of Decadent the Merylend 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be noticed at 1 ☐ Yes 2 No Director Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 341 Vale Summit South 20724 USA Funeral Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Giva 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 72 hours efter 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: by 3 Widowed 4 Divorced White permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Year or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Sales Representative Duron Paint/Wallcover 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumeme) Be Thomas Shultz Ruth Glass 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lois Shultz/Wife 341 Vale Summit South, Laurel, Maryland 20724 Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 ☐ Buriel 2 🎇 Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Washington Cr. 3/13 Laurel, Maryland 21. Signatura Funeral Se 22. Name end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel MINUTE · MASSIVE disease or condition resulting in death) Examine Examiner owout AROTID icien end buriel-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting In deeth) Lest Due to (or as a consequence of): LAMOUS CEIL CARCINOMA physicien e Box 68760, INGEAL Physician/Medical Due to (e es a consequenca of):/ signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to should should 24a. Was en autopsy Completed completion of cause of deeth? aw certificate hes The 2 No 21 No Physician: Be 25. Wes case referred to medical axaminer? 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpetient 3 DOA this funeral 27. Mennar of Deet 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After t or Attending 1 Naturel 2 Accident in 24 hours effer death.

the Funeral Director: Aft 5 Pending Investigation 1 Tes 2 No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicida 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and piece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 30. Name end edgless of person who completed cays of deeth (Item 23e) (Type, Print) EUTAN ST. BALTIMORE 6 32. Registrer's Staneture State Registrar



Please Type or Print in Black indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month George, Shuler March eleven 130 4a Facility Name of not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Sinai Ho Spital Baltimore Cit 6. Sex 10 M 20 F If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthdey) Deys Hours 214.24.7243 Usual Residence of Decedent 10 Yrs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE N MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 3808 NORFOLK 21216 VENUE Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Meritei Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) GRADE NA ONSTRUCTION ONSTRUCTION WORKER TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) GEORGE SHULER KOSALEE OMITH 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BROTHER BALTO. MD. MALON SHULER 20b. Piace of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State MO 3.15.99 BALTO 4 ☐ Donation 5 ☐ Other (Specify) OTAR 22. Name and Address of Facility VAUGHN C. GRE 5151 BALTO. NATL 21. Signature of Funeral Service Licensee FUNERAL SERVICE GREENE augh BALTO. MD. 21229 PIKE. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Death tmmediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of): perosmolar non-ketotic State Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco usa contributa to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24s. Was an autopsy

Physician /Medical Examiner

physician and s the burial-transit

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certificate has b director, page 2 s

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After

24 hours efter death.

within 2 To the the th

funeral

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Completed

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To

Certification:

edical

law requires that the death certificate be executed

or Attending Physician:

Hospital

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examinar must be notified at

Pages 1 end 2 should be filed within 72 hours after death nent of Health end Mental Hygiena.

Health tem 27

permit. Pages Department of Important: If Its any Injury or o

Baltimore, Maryland 21215-0020

with the Maryland

Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initialed events resulting in death) Lest Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25. Wes case referred to medical examiner?

1 Yes 2 No 27. Manner of Deet 1 Neturel 5 Pending investigation

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

Location (Straet end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) and manner es stated.

Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

31. Date filed (Month, Dey, Year)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

Resident Physician Sinai

hrch, eleven, Balto. MD

J. Belwens

MAR 1 6 1999

6 Could not be determined

Hospital 32. Registrar's Signeture

21215

State Registrar

CHARLE SALE OF STREET

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** Sweet 13 , 1999 4c. County of Death Elhel Virginia /Medical 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner ackville enter 7. Aga (In yrs. lest birthday) If Undar 1 Year Months Days 5. Social Sacurity Number Birthplace (State or Foraign Country) **Funeral** 1□ M 20€F Hours 212-82-6799 Usuel Rasidance of Decedent Director ure ircinia with the Maryland ahow 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits traumatic avent, the Medical Examiner must be notified at Director 1 ☐ Yas 2 X No 28a-f 10e. Straet and Number 10f. Zip Coda 10g. Citizan of Whet Country? 6 Нета 23а Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Rece - American Indian, Black, Whita, atc. 11. Maritel Status Pages 1 and 2 should be filed within 72 hours efter onent of Health end Mental Hygiene. Int: if Itam 27 is marked other then "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No If Yas, Giva Yaar or Datas: 1 ☐ Yes 2 No Specify: White Spacify: þ 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Dacadant's Education (Spacify only highast greda complated) 16a. Decadant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be HENRY 10 19a. informant's Neme/Relationship (Type, Ruht) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Depertment of Health en Important: if Itam 27 is i any injury or other trau Lutherville, Md 21093 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1 Buriai 2 Cramation 3 Removal from Stata March Vally MIM. Gald: 1499 22. Nama and Addrass of Facility EVans 4 □ Donation 5 □ Other (Spacify) 1999 21. Signature of Fuperal Service Licensee 23a. Párt 1. Enter tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immedieta Causa (Finai disaasa or condition resulting in deeth) Examiner Physician/Medical Examiner priosclotone vascu Hospital or Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or injury that initiated avants rasulting in daath) Last Due to (or as a consaquance of) attending physician for use es the burie Due to (or as a consequance of): signed by the at d be deteched for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 200 No 3 Probably 4 Unknown zheiners 1 ☐ Yes Completed by been signature 24b. Wara autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? cete hes to page 2 s 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was casa referred to medical axaminar? 26. Piaca of Death (Check only ona) 2 No edical Certification: To Othar: A Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Data of injury (Month, Day Year) 27. Magner of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. injury at Work? 5 Pending Invastigation After Netural To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: All completely filled in by the fu death. 2 Accident 1 TYas 2 □ No 6 Could not be dataminad 3 Suicida 28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 ☐ Homicide 29a. Certifier 12 Cartifying Physician: To the best of my knowledge, daeth occurred at the time, date end place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end manner stated.

6

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0020

State Registrar 31. Data filad (Month, Day, Year) MAR 1 6 1999

30. Nama and address of person who completed causa of daath (itam 23a) (Type, Print)

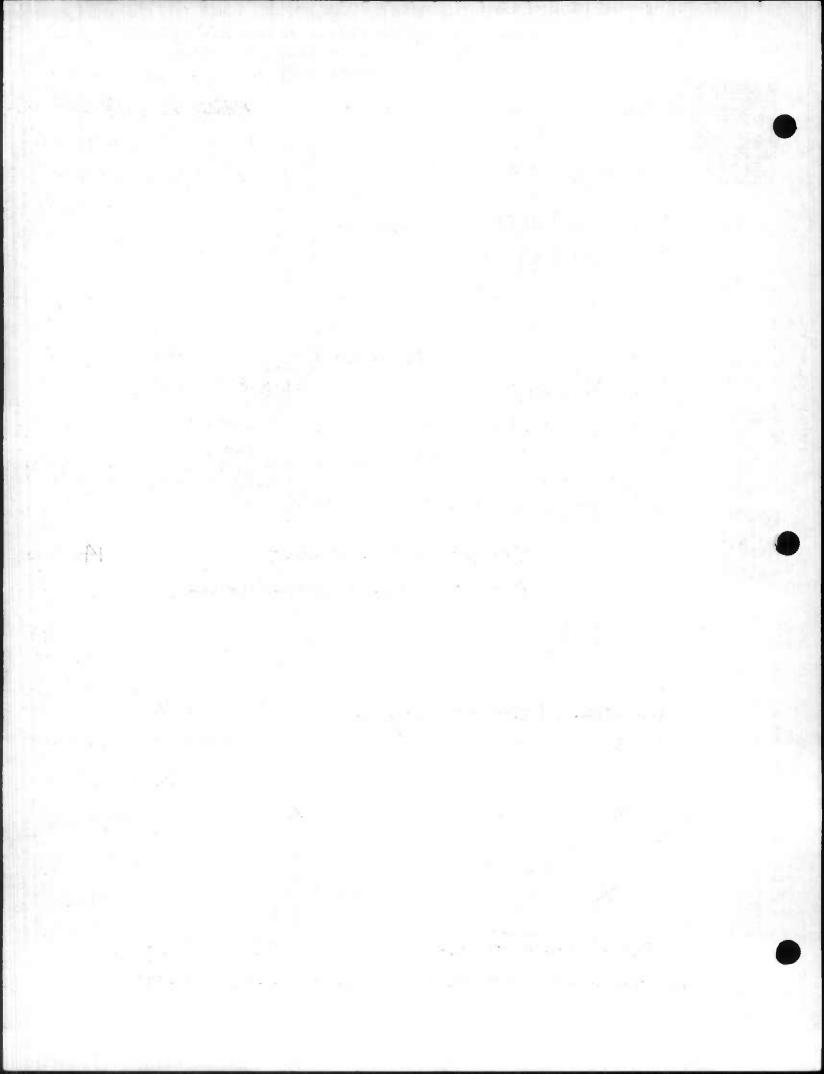
29b. Signature end titla of certifiar



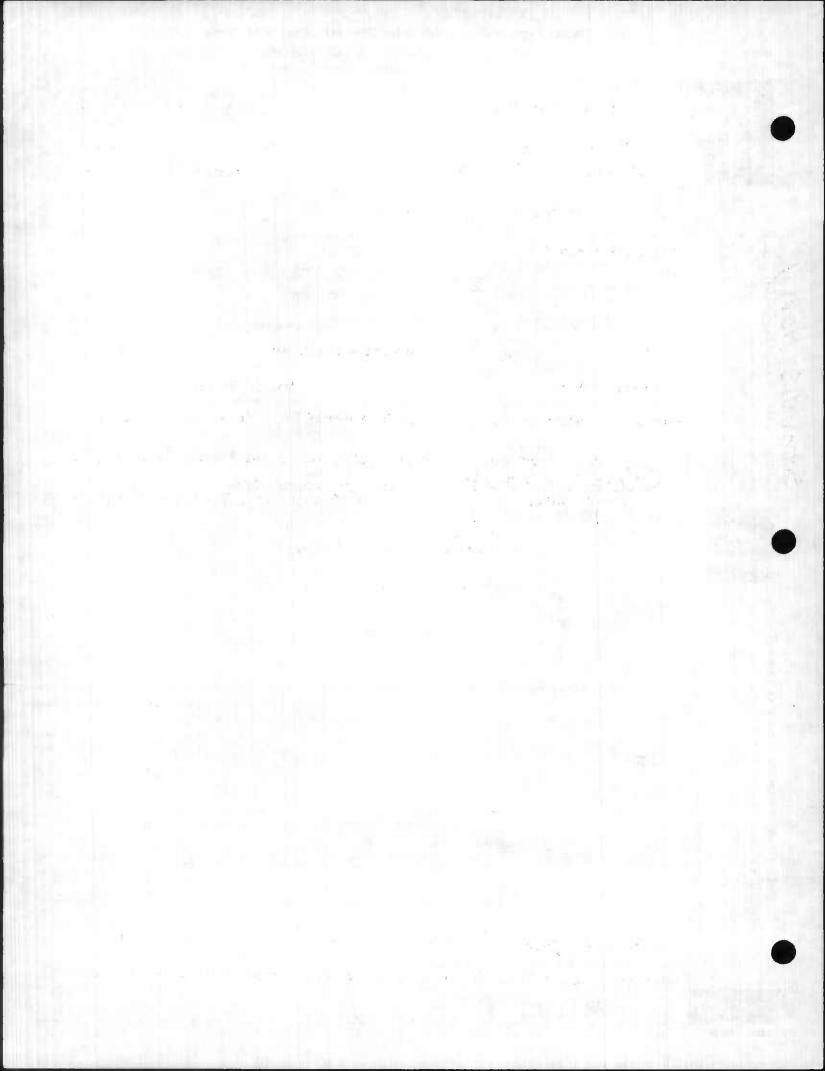
1800 weether Boulerand

29c. License number

29d. Dete signed (Month, Day, Year)



sician	Decedent's Na	me (First, Middle, Last)					2. Dete of De			3. Time of	Death
	Harr	y Albert	Stokvis					March	10 19	99	2:55	AM
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once.		Funeral Service Liseon		_	22. Name end	d Addres	s of Facility					
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10	23a. Part1. Enter shock, or he	the dease, or complete the dease, or complete	lications that caused the ne ceuse on each line.	e death. Do not	enter the mode	of dyin	g, such es cardiac	or respiretory e	errest,		Approxime	ween
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1												200
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Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day JM **Physician** Jean Schroeder March 11, 1999 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hunt Valley M Under 24 Hrs. 8. De 6 Jules Brentony Ct. Baltimore If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Hours 53 Yrs Director 138-38-1974 Feb. 6, 1946 NY Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. na 23a or 28a-f ahor must be notified at 1 Yes 2 No Director Baltimore Hunt Valley 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 6 Jules Brentony Ct. Funeral 21030 USA flems . 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yaer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indian r than "natural", or item the Madical Examiner Bleck, White, etc. 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 7 is marked other traumatic avent, Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finant of Health and Mental I int: If Itam 27 is marked of Francis Cwik Elizabeth Kastner 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Schroeder/Husband 6 Jules Brentony Ct. Hunt Valley, MD 21030 other 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stete March 13, = 6 Department of Important: If any Injury or Baltimore Washington 1999 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD Crematory 21. Signature of Eunepat Service Monte 22. Name and Address of Fecility Lemmon Funeral Home of Dulaney Valley, Inc. Michael Vlagle 10 W. Padonia Road Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cholanyo carcino ma Immediate Cause (Final disease or condition resulting in death) buouths /Medical Examiner Examiner or Attending Physician: The law requires that the death cartificate be executed the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): usa as signed by the at d be detached for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2K No 3 Probably 4 Unknown Division of Vitai Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 has 2 No certificata 1 Yes 1 ☐ Yes 200No funaral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftar 1 Neturel 5 Pending 1 Yes 2 No 2 Accident investigation hours after death uneral Director: / daath 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. Medicai 29a. Certifier DIRECTOR, 29c. License number 29d. Date signed (Month, Day, Year) WEDICALONCOLOGY March 11, 1999 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Baltimore, MD

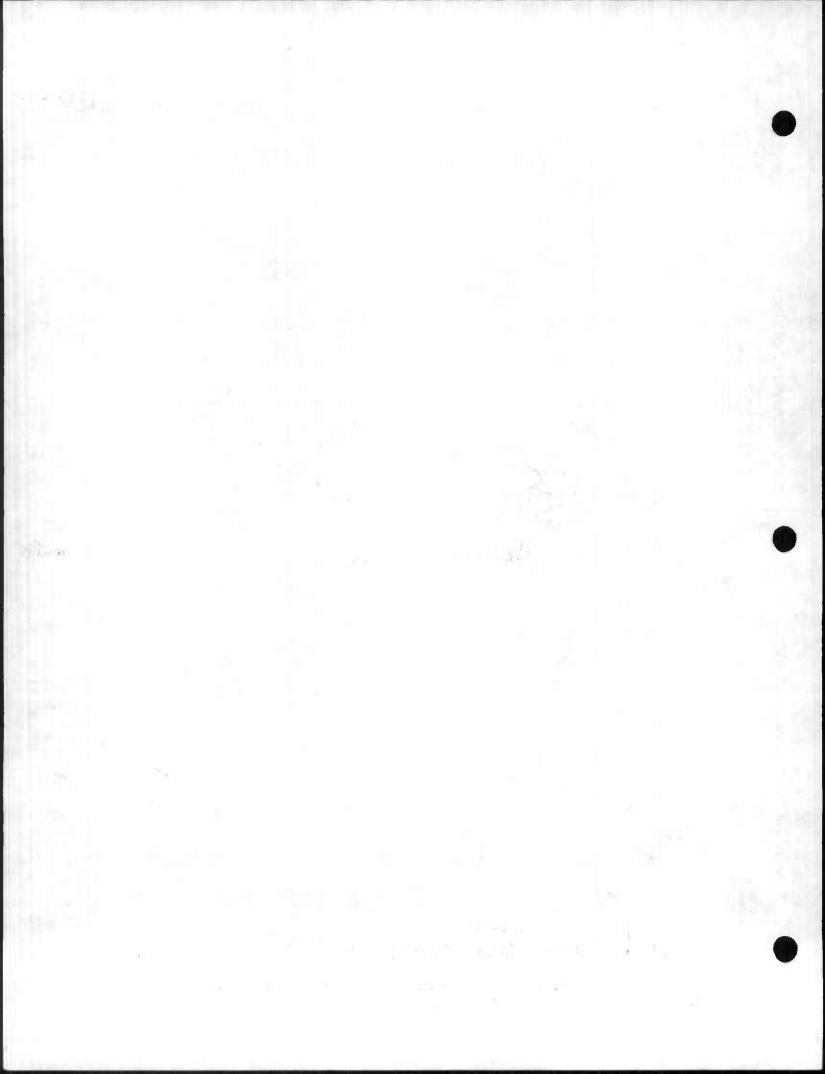
600 N. Wolfe St.,

32. Registrar's Signature

Ross Donehower, MD

MAR 16

31. Dete filed (Month, Dev. Year)

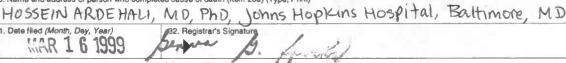


Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March II **Physician** SIMMS 6'00 Am Gregory /Medical 4b, City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Hopkins Hospital paltimore Johns 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplace (Steta or Foraign Country) **Funeral** Months Days Hours. 1 X M 2 □ F Director 214-56-7955 46 M.D. Usuel Residence of Decedent the Mentenc 10c City Town or Location 10a State 10b County 10d. fnside City Limits Peges 1 and 2 should be filed within 72 hours effer deeth with the Merylei nent of Health and Mental Hygiene. Intit if flem 27 is marked other than "natural", or fiems 23a or 28a4 show irty or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2 ☑ No Director MD Baltimore Co. Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21133 5 Jonville Ct. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) Wes Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yas, Give Year or Dates: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collage (1-4or 5+) Dept of Inselor Juvenile Justice
18. Mother's Name (First, Middle, Maidan Sumame) Juvenile Counselor 12th grade 4yrs 17. Fether's Name (First, Middle, Last) Be Gwendolyn Haywood Leander Simms 19b. Mailing Address (Streat and Number or Rurel Route Number, City or Town, Stata, Zip Coda) 19a. Informent's Neme/Ralationship (Type, Print) 5 Jonville Ct, Randallstown Md 21133 Sylvestine Simms-Wife 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If any injury or once. Arbutus Memorial Park 3/16/99 Arbutus, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funerel Service Licansee March F/H West al 4300 Wabash Ave, Baltimore Md entar tha mode of dying, such as cardiac or raspiretory errest, 21215 23a. Part1. El tar tha disease, or complications that caused the death. Do not enter shock, or heart failure. List only one ceuse on each line. Approximate Intarval Between Onset and Death **Physician** /Medical immediate Causa (Finel 1 week a. Thrombotic Thrombocytopenic Purpura/HUS disease or condition resulting in death) Examiner Dua to (or es e consequence of): Examiner 2 months Graft versus Host disease end I-transit Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Ceuse (Disaasa or Injury that Initiated events resulting in death) Last Dua to (or as e consaquance of): buniel physician s the buriel 2 weeks P.O. Box 68760. Renal Failure Physician/Medical Dua to (or as a consequence of): 98 GI bleeding USB 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. been signed by the should be detached 1 Yas 2 No 3 Probably 4 Unknown A cirle Myelogenous Division of Vital Records. þ 24b. Were eutopsy findings aveilabla prior to completion of ceuse of death? 24e. Was en autopsy Completed liver dysfunction page 2 1 ☐ Yes 2 No 1 ☐ Yas 2 X No certificate or Attending Physician: director, 25. Was cesa rafarrad to medical examinar? Be 26. Plece of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: Lo 1 Yas 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 Suicide 6 Could not be datarminad 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida 1 Actifying Physician: To the bast of my knowledge, daath occurred at the time, dete and place, and dua to the ceusa(s) end manner as stated.

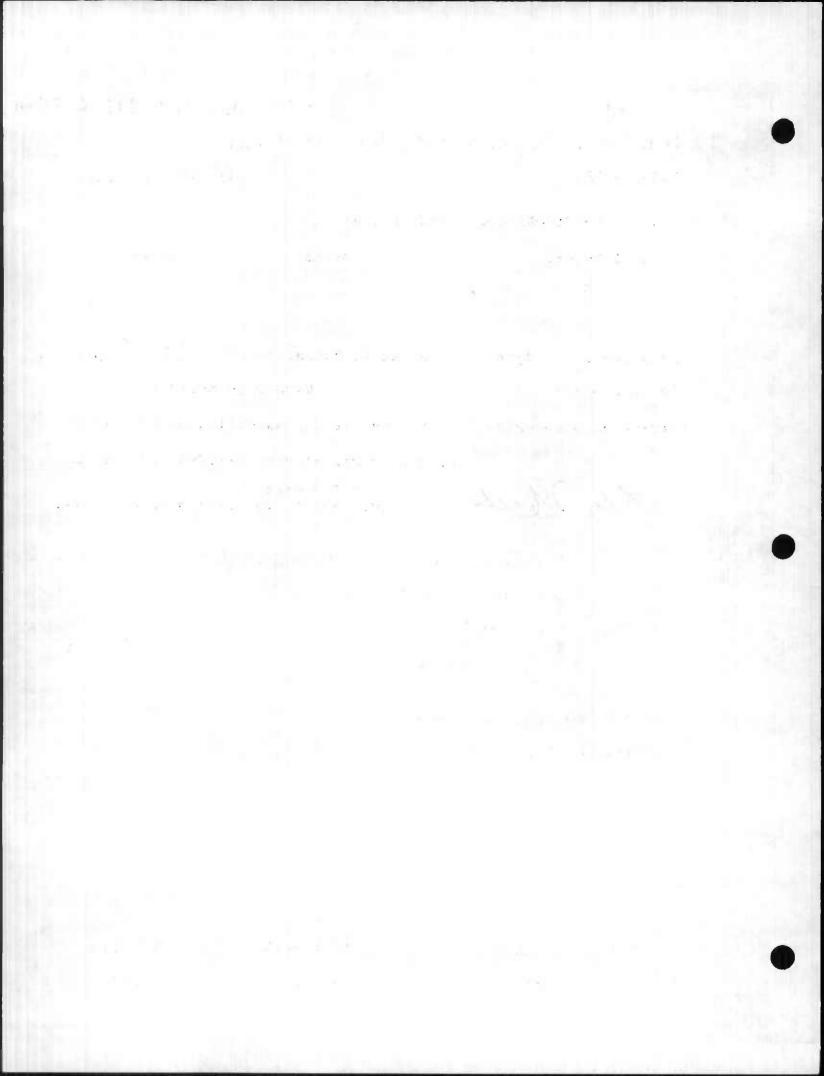
2 Madical Examinar: On the basts of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) end manner stated. 29a, Cartifiar edical 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Olidehal , MD, PhD RES-000 3/11 199

Registrar

31. Dete filed (Month, Dey, Year)



30. Name end address of person who completed cause of daath (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1 Decedent's Neme (First Middle Last) Month 11:35A , 1999 March 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Baltimore enter Long Gre 5. Sociel Security Number Nunsina Green If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplece (Stete or Foreign Country) 1□M 2XF Months 214-12-4219 Yrs. 92 DEC 10 1906 SOUTH Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MARYLAND N/A BALTIMORE CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2207 LYNNBROOK AVENUE 21217 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Race - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify: Specify: BLACK 3℃Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) HEALTH CLEANING HOSPITALS unknown 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) FRANK WILLIAMS MISIE WILLIAMS 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21239 MARY SMITH/SISTER-IN-LAW 1630 Walterswood Rd., Baltimore Maryland 20e. Method of Disposition 1 ☑ Permovel from State 20b. Place of Disposition (Neme of cametery, crematory or other plece) Dete 20c. Location - City or Town, Stete ARBUTUS MEMORIAL 3 - 18BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Farline Immediate Ceuse (Finel disease or condition resulting in death) Heart Congetire Due to (or es e consequence of): Due to (or es e consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hypothy des Due to (or es e consequence of) resulting In death) Lest 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Jomt 24b. Were autopsy findings aveilable prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 24 No 1 Yes 22 No 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Horsing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

ettending physician end for use as the bunal-transit the death certificate be executed Box 68760 ed by the e signed by t requires thet been : The law certificate has Division of Vital Physician: After this of funeral dir or Attending ours efter death.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Exampler must be notified at

7 is marked other than traumatic event, the Man

permit. Pages 1 end 2 sh Depertment of Health and Important: If Item 27 Is m any Injury or other traum page.

Physician

/Medical

Examiner

Physician/Medical Examin

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Completed

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Certification:

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death

72 hours efter

filed within 7 Hygiene.

2 should be f

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical examiner?

1 Yes 2 No 27. Manner of Death

1 Naturel 2 Accident 3 ☐ Suicide 4 Homicide

5 Pending Investigation 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Cartifying Phyalcian: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end manner as stated.

2 Madical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier

29c. License number D 31464 29d. Date signed (Month, Dey, Year)

MD

3/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHOAIB A- HASHMI MD, \$21 N. ENTAN ST INTE 304, 13alt m1) 2120

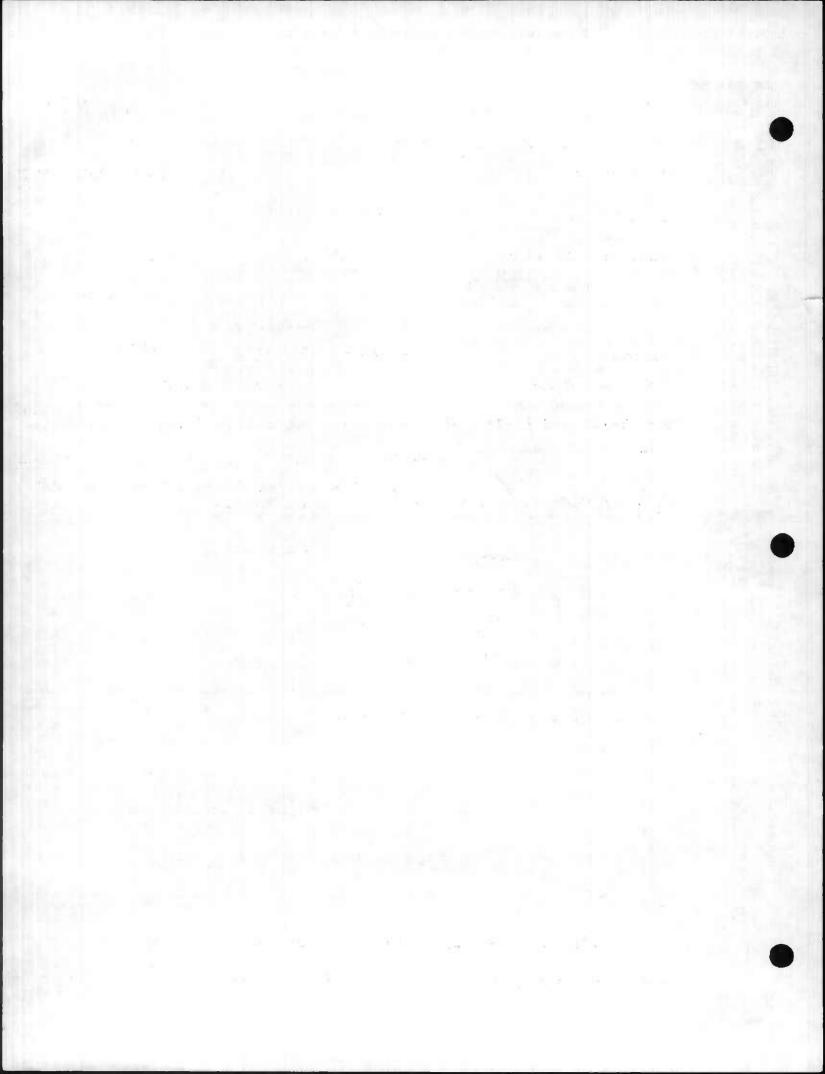
31. Dete filed (Month, Day, Yeer)

MAR 1 6 1999

32. Registrer's Signeture

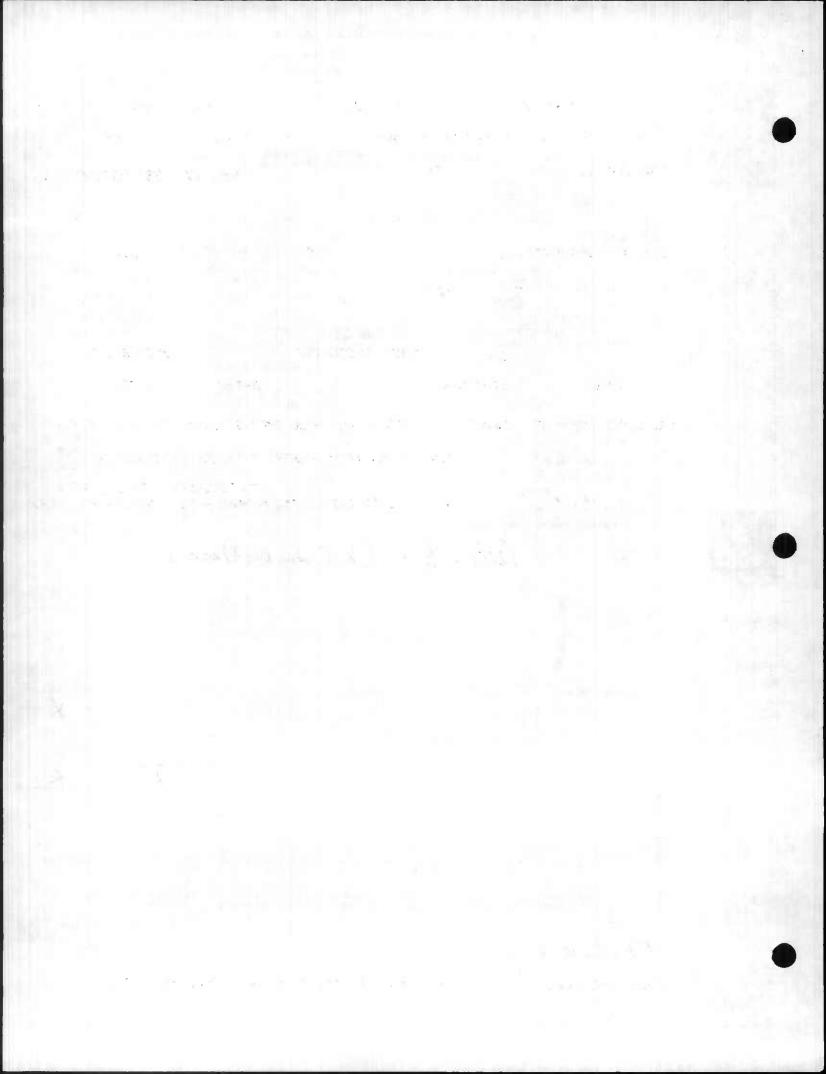
State Registrar

To the Hospital within 24 hours e To the Funeral C completely filled Hospital



State of Maryland / Department of Health and Mental Hygiene

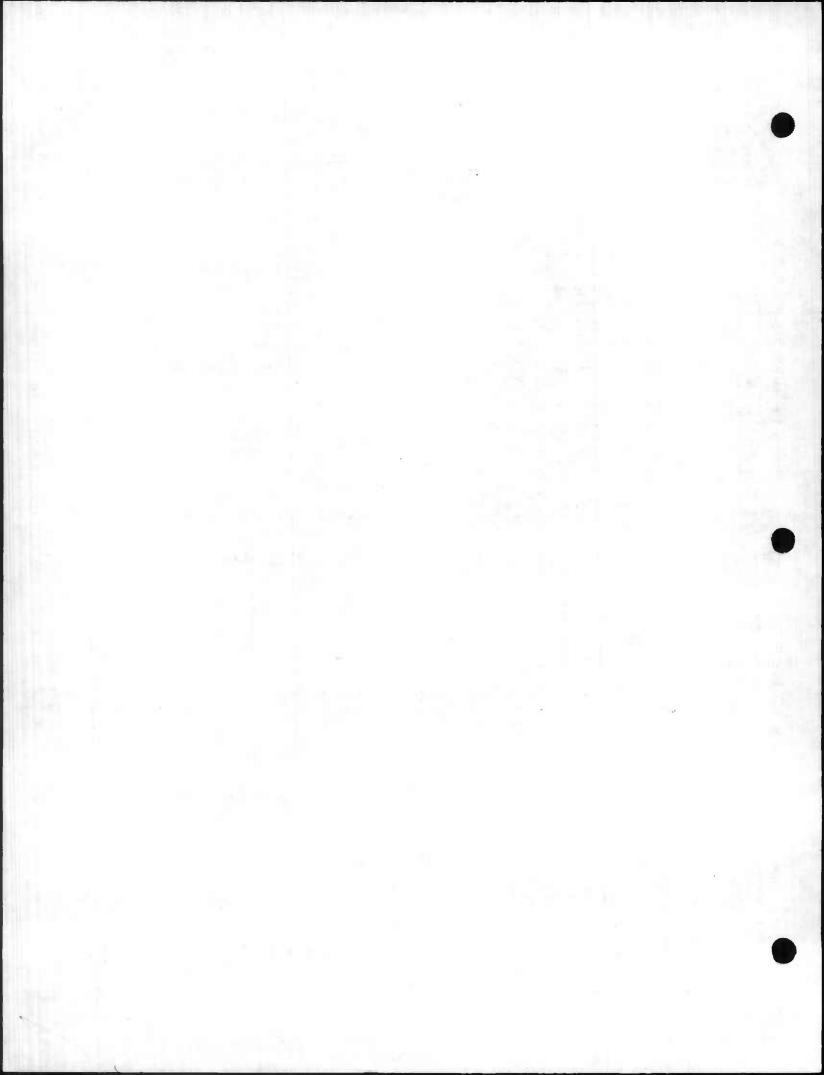
TZ.				Ce	rtificate	e of	Death			Reg. No.	0 0	Sa V/ No	
	1. Decedent's Nama (First, Mic	idie, Last)					140		2. Dete of De		V	3. Time of Death	
Physician /Modical	I	BERTRAM	PHILIP	S	CHWART	rz			Month MARCH	I 10, 19	Yeer 199	9:55 PM.	
/Medical Examiner	4a Facility Nama (If not institut 5247 REISTER	ion, giva straat and r RSTOWN RD.	(HOUSE	OF HO	PE)			wn, or Lo	cation of Death	4c. County	of Death		
Funeral Director	5. Social Security Number 162–28–5456	6. Sax 1 ☑ M 2 ☐ F	7. Age (In yrs.	lest birthday) 54 Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Deta of Bird (Month, De AUG. 1	th y, Year) .7, 1934		ece (Stete or Foreig ry) SYLVANIA	
2 >	Usuel Residence of Decedent 10a, Stete 10b, Cour		100 0	Town as La	i				10d. insida City I				
or 28a-f show be notified at Director	MD 10b. Cour	N/A	100. 01	BALTIN								1 X Yas 2 N	
0 20	10e. Street and Number 5247 REISTER	RSTOWN RD.	• 21215						10g. Citizen of Whet C			y?	
72 hours effer death variations 134 1 and Eventuer must seted by Funeral	11. Maritei Status 1 ☒ Never Marriad 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce	Armed	Armed Forces? If			lant of H sify Cub	dispanic Orl en, Mexicer Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	Blad	ce - America ck, Whita, et v: WHI.	tc.	
natur natur	15. Deced	ent's Education hest grade complete	d)	16a. Dece	dent's Usua	l Occup	oation during mos	t of worki	ina	16b. Kind of B	usinass/Indu	ustry	
ygiena. Per than "natural, the Wedge	Elementery/Secondary (0-12) College	(1-4or 5+)		DO NOT US DR ACC		during mos d) TANT			ACCO	UNTING	G	
avent, Be Co	17. Fathar's Neme (First, Middle	a, Last)		11			18. Mothe	er's Neme	(First, Middle,	Malden Suman	ne)		
th and Mental Hygy T is marked othe traumatic svem,	LOUIS	S	CHWARTZ					MI	RIAM	LE	VIN		
and s sums	19e. Informent's Name/Reletio	nship (Type, Print)		19b. Meili	ng Address	(Street	and Numb	er or Rura	al Route Numb	er, City or Town,	Stete, Zip C	Code)	
permit. Peges 1 and 2 Department of Health Important: if Item 27 I any Injury or other tri once.	DR. LIOYD STE	n 3 🗆 Ramoval from	m State	1190 Plece of Dispondenterly, cres SHE EMU	osition (Nem matory or of	ne of ther pla	ce)		Dete	ALTIMOR 20c. Location BALTIM	City or Tow	vn, Stete	
eeth certificate be assected established. ettending physician and for use es the buriet-transit claryMedical Examiner	23a. Pent 1. Enter the disease, shock, or heart failure. L Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	e b d	Due to (c		quence of):				Ois	4		Approximate Intervel Between Onset end Deeth	
the ettence the for us	Pert II. Other significant condi	tions contributing to	death but not res	sulting in the u	nderlying co	euse gi	ven in Pert	l.	23b. Dld	tobacco use co	entribute to	the cause of deat	
ed by detac				<u></u>					10	Yes 2□No	3 Probe	ably 4 Unkno	
has been s the 2 should mpleted			÷							an autopsy ormed? / Chan Yes 2 No	evei com of de	re eutopsy findings ileble prior to apletion of cause leeth?	
certificata	25. Was cese referred to medi exeminer?	cel					26. Place	e of Deetl	h (Check only	one)			
di di	1 ☐XYes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpetie		/A		ursing Ho	me 5 Resi	dence 6 □Oth	ner (Specify))	
After	3 ☐ Suicide 6 ☐ Coul	stigetion d not be	28b. Time of 28c. Injury et					28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
in the hospital or attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat		ring Physician: To the series of the series											
within 2 To the comple	29b. Signatura and title of certi		70.00		290	. Licens	sa number	1.E.		29d. Data signe			
State	30. Neme end eddress of person HEUNOLE A 31. Dete filed (Month, Day, Yes	likay		.11 Pen		eet			re, Mar	yland 2			



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Beatrice Spera March 14, 1999 7:45AM /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1302 Gill Street Odenton Anne Arundel 8. Data of Birth (Month, Day, Year) Jan. 21,1914 If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Devs 1□ M 2X F 217-16-5893 85 Director Maryland Usual Rasidence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show 1 ☐ Yes & No MD Anne Arundel Director Odenton 28a-f 10e Street and Number 10f Zin Code 10g. Citizen of What Country? ò 1302 Gill Street 21113 USA Berra 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? filed within 72 hours after 1 Nevar Married 2 Married 1 ☐ Yas 2) No If Yas, Giva Saltimore, Maryland 21215-0020 8 1 ☐ Yas 2X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Licensed Operator Daycare 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surnama) Pages 1 and 2 should be fit ment of Health and Mental H ant; if them 27 is marked off lary or other traumatic even Be Ignatuis Ostrowski Tillie Borron 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Preslipsky (Friend) 362 Baltimore Avenue, Odenton, MD 21113 20e. Mathod of Disposition 20b. Ptace of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from Stata Department of Important: If any injury or once. 03/16 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Hardesty funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** /Medical Immediate Causa (Final accident diseasa or conditio rasulting in death) Examiner Dua to (or as e consequence of): Examiner ician and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaase or Injury that initioted evants rasulting In death) Last Dua to (or as a consequence of) physician at the burial P.O. Box 68760. Physician/Medical Dua to (or as e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown should be det Division of Vital Records. þ 24b. Wara autopsy findings available prior to complation of cause of deeth? Completed 24a. Wes an autopsy performed? page 2 1 Yas 2 No 1 Yes 2 N MG certificate or Attending Physician: director, Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mennes of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Panding Invastigation 1 Netural after death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarminad 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Funeral C Hospital 29a. Cartifier 🗗 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end manner as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and mannar stated. within 2 \$ 29b. Signature and title of carriller Do. License number 29d. Data signed (Month, Day, Year) 0 30. Name end addrass of person with complated causa of daath (Item 23a) (Type, Print) GlenBurnie mp 2106 1600 S. Crain Hwy #106 Charles Wumo 31. Data filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 6 1999 Registrar

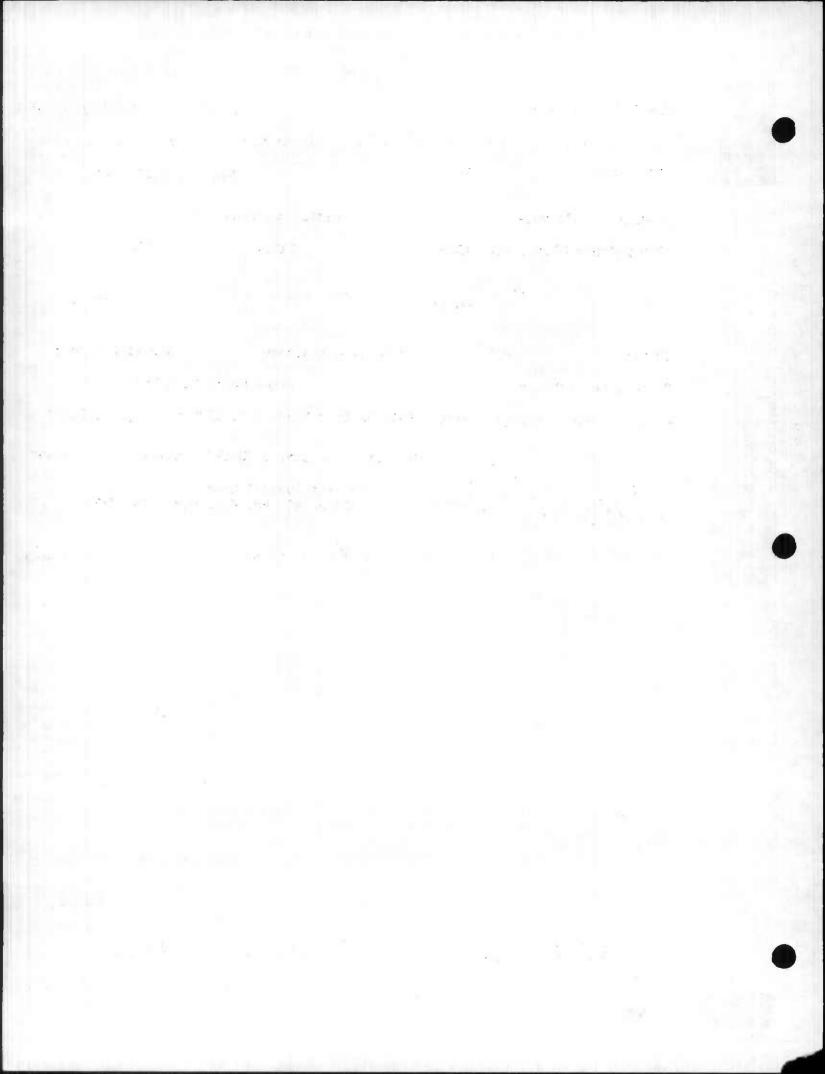
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	Certifica	te of Death	Reg. No.	
	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physicia: /Medica	DEMNICTU D. CCULLCLI		Month Day	0 1999 7:05 PM
Examine	An English Name (If not institution give street and grapher)	4b. City, Town, or Lo	ocation of Death 4c.	County of Death
• • •	FRANKlin Square HospiTAl Center	RasedA	10 B	AlTimore
Funeral	5. Social Security Number () 6. Sex 7. Age (In yrs. last birthday) If Und	er 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yeer)	Birthplaca (State or Foreign Country)
Director	207-03-8101 12 M 2 F 78 Yrs. Months	B Days Hours Min.		920 PA.
	Usual Residence of Decedent		UUIIE 17, 1	J20 IA.
filed within 72 hours efter death with the Meryland Hygiena. Ther than "natural", or items 23a or 28a-f show mt, tre Mod cal Examiner mant be notified.	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Men I	Maryland Baltimore	Baltimore Cou	unty	1 ☐ Yes 2 ☑ No
the rich	10e. Street and Number	ip Code	10g. Citiz	ten of What Country?
23a o	8810 Walther Blvd . Apt. 1525	21234		USA
10.2	Maryland Baltimore 10e. Street and Number 8810 Walther Blvd . Apt. 1525 11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent Ever In U,S. Armed Forces? 15. Was Decedent Ever In U,S. Armed Forces 15. Was Decedent Ever In	edent of Hispanic Origin? (Sp	ecify Yes or No-	4. Race - American Indian,
Examiner or	Armed Forces? If Yes, sp 1 Never Married 2 X Married Yes, Sive 1 Yes	ecity Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
0	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW 11	212 No Specify:		Specify: White
natural.	15. Decedent's Education 16e. Decedent's Us	ual Occupation	16b. Kir	nd of Business/Industry
u pa	(Specify only highest grade completed) (Give kind of w	ork done during most of work use retired)	ring	
5	Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. N/A Locomot:	ive Engineer	Con	rail Railroad
			e (First, Middle, Meiden	Sumeme)
De o	17. Father's Name (First, Middle, Last) Raymond Guy Schlegel	Ethel	Marie Gotts	shall
1		ss (Street and Number or Run	ral Route Number. City or	Town, State, Zip Code)
1 2				to., Md. 21234
other	20a Method of Disposition 20b. Placa of Disposition (N		Date 20c. Loc	cation - City or Town, State
= 6 = 6	Cemetery, cremetory or	Faith Cem. 3+1		Ltimore, Maryland
dury dury			13-1333 041	ttimore, maryrand
my in		and Address of Facility assahn Funeral	Home	
2 8 0		401 Belair Rd.		Md. 21236
	231 Page the disease of complications that caused the death. Do not enter the most of heart failure. List only one cause on each line.	de of dying, such as cardiac	or respiratory arrest,	Approximate interval Between
sician	die catagori each mie.			Onset and Death
edical	Immediate Cause (Final disease or condition	Pheumor	1.0	Fire Days
iner	resulting in death) a. 110 1 e Due to (or as a consequence of		110	11/20493
		,.		
ansi	b):		
19-1-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	,-		
ng e	Cause (Disease or Injury that Initiated events	1.		
as th	resulting in death) Last	P.		
esn				
for			1	
chec	Pert II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		use contribute to the ceuse of deeth?
deta			1 Yes 2	No 3 Probably 4 Unknown
			24a. Was an autop	sv 24b. Were autopsy findings
houl			performed?	available prior to
6 2 8				of deeth?
pag			1 Yes 2	No 10 Yes 2□ No
al director, page	25. Was case referred to medical		th (Check only one)	1
direc	1 Yes 20 No Hospital: 1 Incatient 2 FB/Outpatient 3 F	OOA Other: 4 Nursing Ho	ome 5 Residenca 6	□Other (Specify)
nera		28c. Injury et Work?	28d. Describe how injury	y occurred
in fur	1 Anatural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	1 Yes 2 No		
to the Fundral Director: After this centificate has completely filled in by the funeral director, page 2:	3 Suicide 6 Could not be determined 28e. Plece of injury - At home, ferm, street, factor	ory, office	28f. Location (Street and	d Number or Rural Route Number,
led in by the funera	4 ☐ Homlcide determined building, efc. (Specify)		City or Town, State)	
completely filled in		d et the time, date end place	end due to the cause(s)	and manner as stated.
pietely fil	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurr	red at the time, date and	placa, and due to the cause(s)
jdwo		9c. License number	29d. Date	e signed (Month, Day, Year)
8				
1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR RiTA MATHUR 9000 FRANKLI'N SQUARE 31. Date filled (Month, Day, Year) RAR 1 5 7999 Appendix 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	RD 1918.	25 31	10/11
to-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 0 15	The Value	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
JE	DRKILA MAIHUR YOOO TRANKlin Square	DR. BALLIN	MORE, MAR	4/And 21231
State	31. Date filed (Month, Day, Year)	19		
Registra	MAK T 9 1939 10. 10. 10. 10.	UNITY TO THE STATE OF THE STATE		

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State of Maryland / Department of Health and Mental Hygiene



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

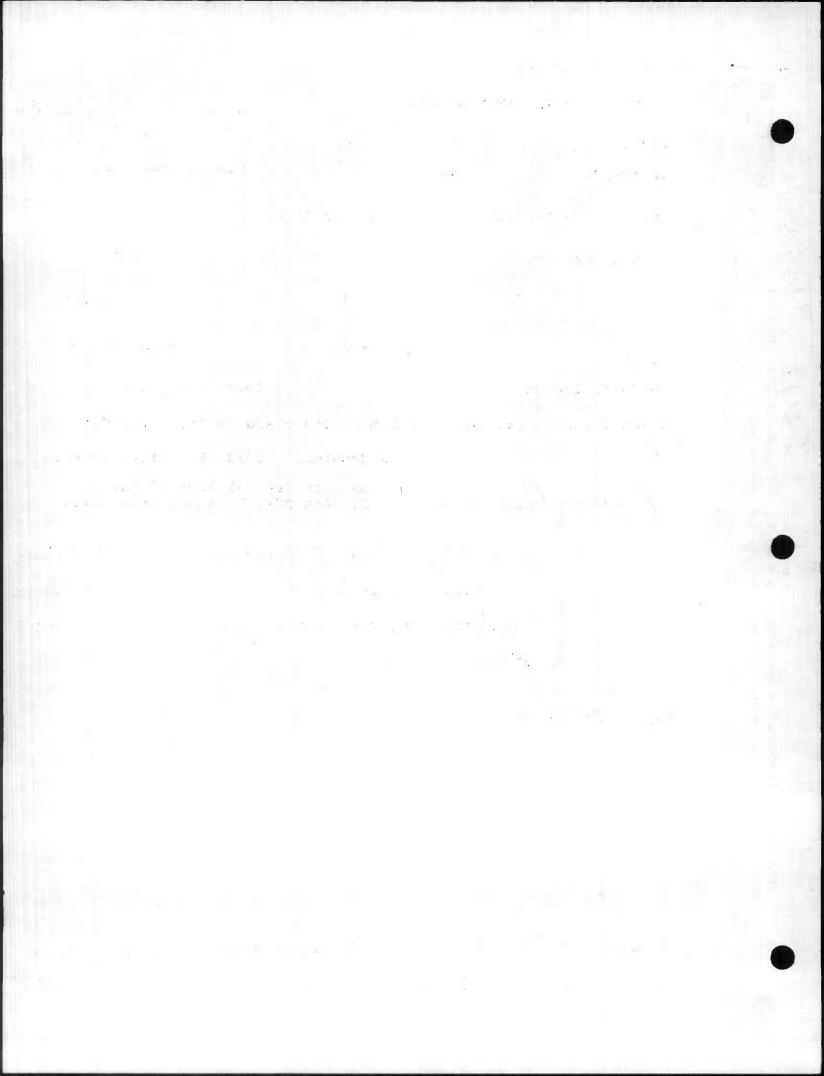
State of Maryland / Department of Health and Mental Hygiene Items: 7.8 per F.H G-769 3/16/99 reb Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOSEPH CARL THOMAS SR. 3:30 AM March /Medical 4a Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale
If Under 24 Hrs.
Hours Min.
Dec. 15 Franklin 5. Social Security Number enten If Undar 1 Yaar altimore guare 05 Ita Year 1922 1921 Birthplace (State or Foreign Country) Social Security Number & Sev 7. Age (Ill yrs. last birthday) **Funeral** Days Months 158 M 2□ F 77 76 Pennsylvania 166-16-1815 Director Usuel Residence of Decedent 10d. inside City Limits 10a State 10h Counts 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-1 show with injury or other traumatic event, the Medical Examiner must be not the data once. Middle River 1 ☐ Yes 2 No Baltimore Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 2 Starwood Court Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
to Yes 2 No
if Yas, Give
Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian 11 Maritai Status Black, White, atc. 1 Navar Married 2 Married 1 Yes 3€ No Specify: Specify. þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Millwright General Motors 12th 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fathar's Nama (First, Middle, Last) Herbert Thomas Florence Algiers 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Relationship (Type, Print) 930 Buckland Place BelAir Md. 21014 Joseph C. Thomas Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cramation 3 Ramoval from State 3/13/99 OakLawn Cemetery Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funeral Service Licenti Connelly Funeral Home of Essex 300 MAce AVe. Baltimore Md. 21221 onn 23a. Part 1. Enter the disease or shock, or heert failure. List omplications that caused the death point enter the mode of dying, such as cardiac or respiratory errest any one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Infanction Acute Myocardia Examiner Examiner Blood lassive bunal-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Last Due to (or as a consequence of) and physician a Division of Vital Records, P.O. Box 68760, Aneurysm Physician/Medical Due to (or as a consequence of): Htherosclerosis esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown igned l þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medicel exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation efter death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours edical 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certified AT2438946.N33 March death (Item 23a) (Type, Print) Square Drive Baltimore, Maryland 9000 Franklin 31. Date filed (Morth, Day, Year) 32. Registrar's Signature State MAR 16

DHMH 16 Rev 6/95

Registrar

1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Thomas Jesse /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Hospital Agnes Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 15 M 2□ F M3 224-26-6305 Yrs. Director Usuat Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiena. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinal must be notified at 10e. State 10c. City, Town or Location 10d. Inside City Limits NA Md Baltimore TO Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2913 N. Rogers Avenue U.S.A 21207 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Black Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Arrow Cab Company Elementary/Secondary (0-12) 12419 rade College (1-4or 5+) Engine Machanic NA 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Mary E. Thomas James 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Wife 2913 N. Kogers Avenue Tayola Balto, Md 21207 homas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Important: If its any injury or o once. Burlat 2 Cremation 3 Removal from State Cenetery 3-17-99 oodlawn 4 Donation 5 □ Other (Specify) 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility Print. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one seuse on each line. Balto, Md 21215 ubbash Avenue Physician tmmediate Cause (Finat disease or condition resulting in death) /Medical artery Coronary Examiner Due to (or as a consequence of) Physician/Medical Examiner Hypertension attending physician end for use es the burial-transit Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Diabetes mellitus that initiated events resulting in death) Last Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Gnknown Renal Failure þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed CVA cartificate has to lirector, pege 2 s 1 Yes 2 doNo 1 Yes 2 Wo 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Plo Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Naturat 1 Yes 2 No 2 Accident the Funeral Direction of the Funeral Direction 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

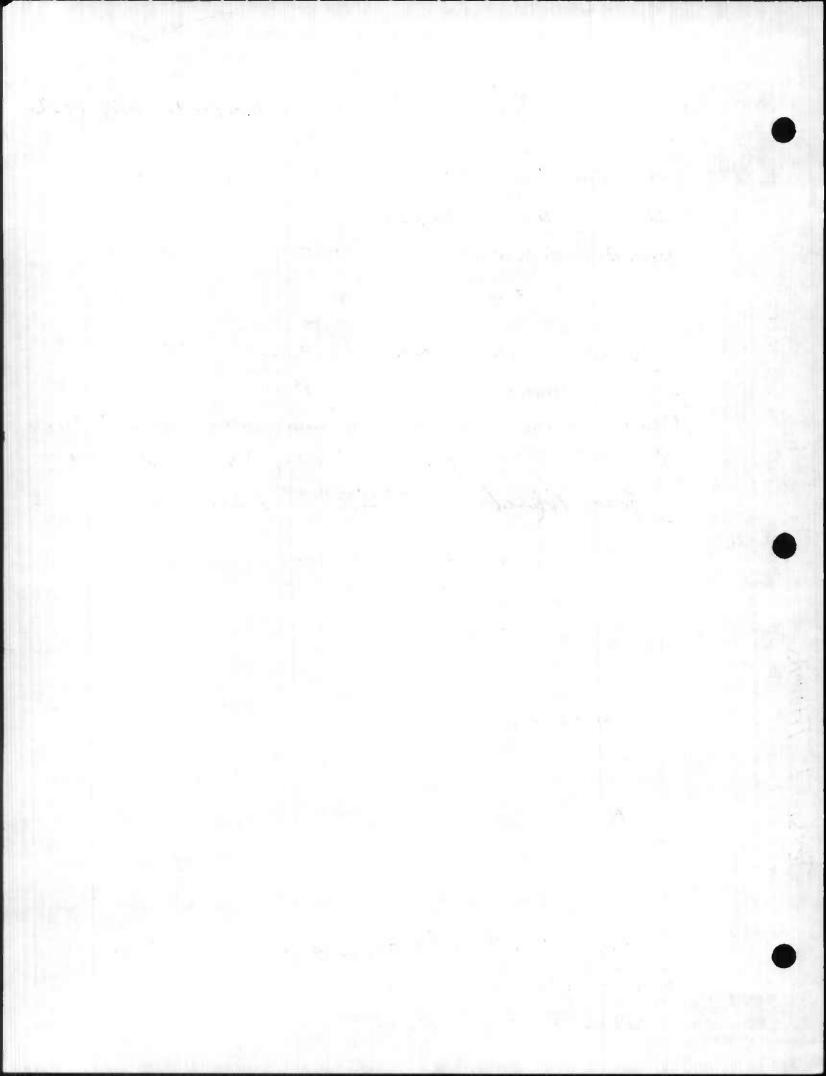
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hou To the Fune completaly fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number D0053312 March 11, 199 9 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Baltinore Michelle Hengseler Caton Avenue, 900 32. Registrer's Signature 31. Date filed (Month, Day, Year)

oaks

DHMH 16 Rev 6/95

Registrar

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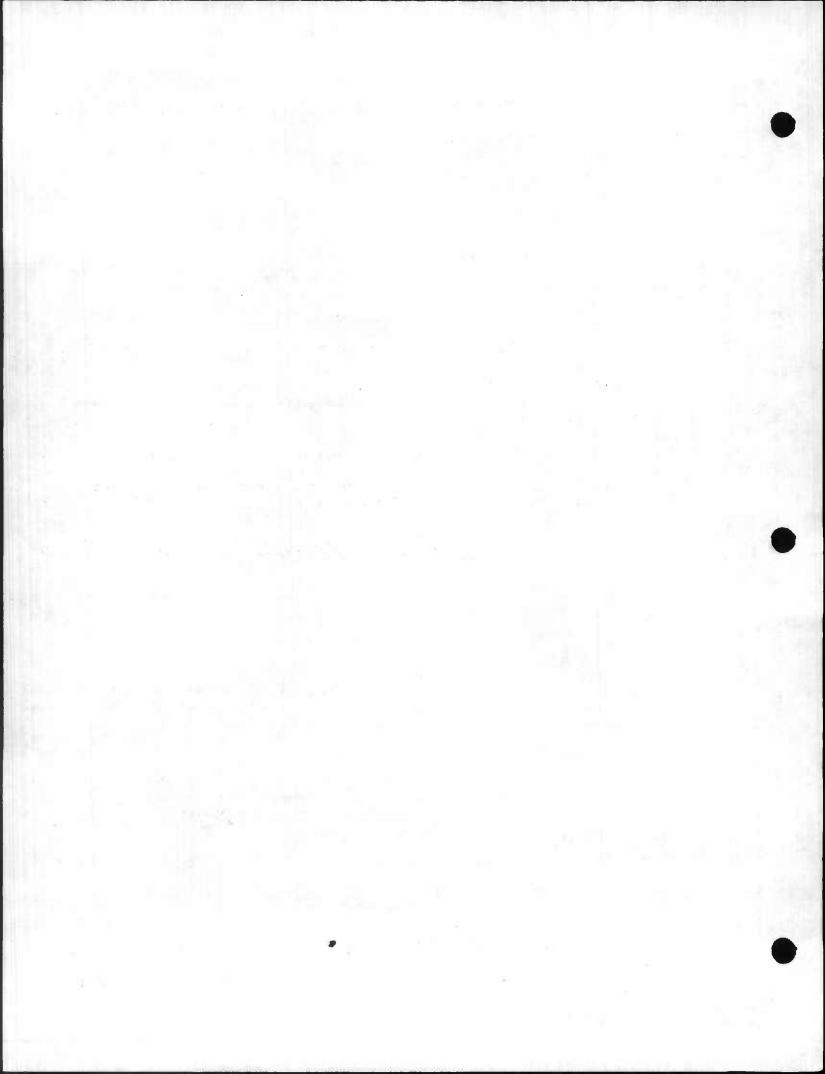


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State of Maryland / Department of Health and Mental Hygiene

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law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

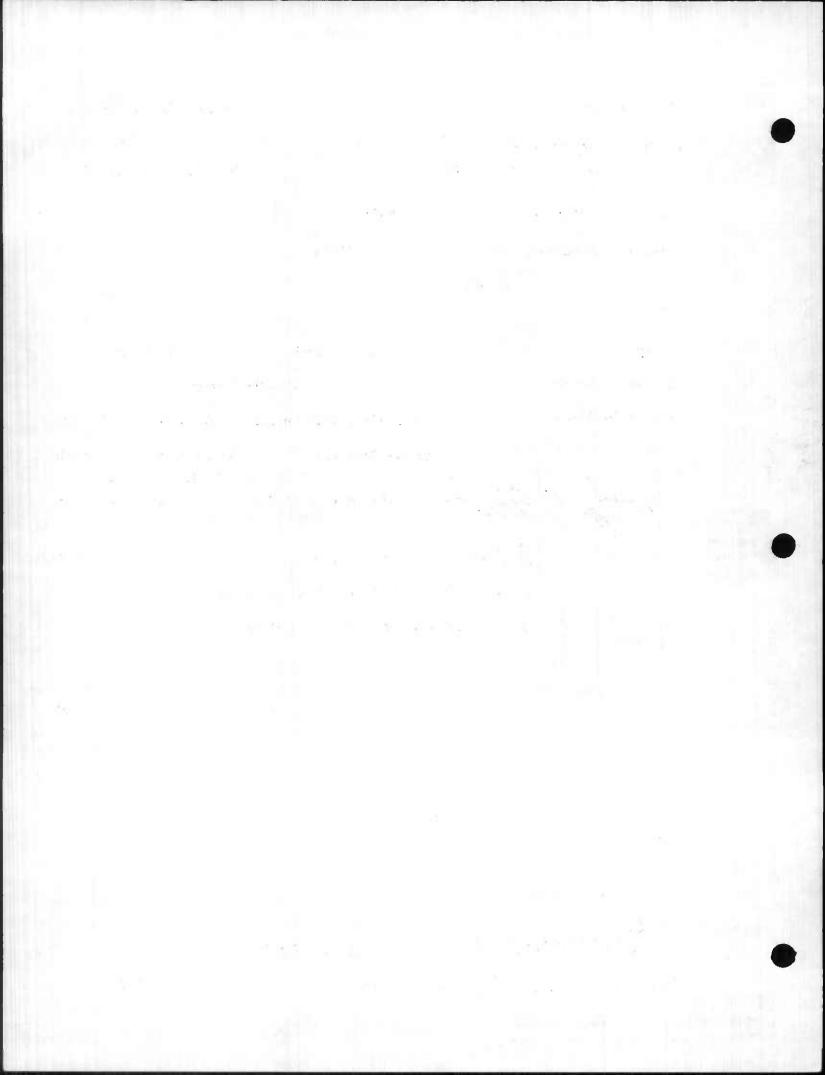
Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month **Physician** 6:50 P.M. Kathleen Lois Todd 1999 MARCH /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner FRANKlin SquARE HOSPITAL 5. Social Sacurity Number 6. Sax 3. Aga (In you CenTer KOS@ d 4 /e

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Ye
Oct. 13, rosedale BAITIMORE 9. Birthplaca (Stata or Foreign Country) Virginia Aga (In yrs. last birthday) **Funeral** Year) Days 1□ M 2⊠ F Months 69 219-22-7567 Director Usual Residence of Decedant the Manylend 10a Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Baltimore Perry Hall 1 Yas 2 No Director 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 9411 Seven Courts Drive 21236 U.S.A. Funeral filed within 72 hours efter death 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: White altimore, Maryland 21215-0020 Specify: þ 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Pharmacist Tech. Food Store permit. Peges 1 and 2 should be filed Department of Heelth and Mental Hygi Important: If Item 27 Is marked other 18. Mothar's Nama (First, Middle, Maidan Surnama) 17. Father's Name (First, Middle, Last) Herman Smith Brunetta Brooks 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Rollin Todd/Son 1119-2A Castle Harbor Way Glen Burnie MD. 21060 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 □ Burial 2 □ Cramation 3 □ Removal from Stata Parkwood Cemetery 3/17/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licensae 22. Nama and Addrass of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 e, or comblications that cadsad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Physician** /Medical Immediata Causa (Final a. A utonomic Instability
Dua to (or as a consaquanca of): 6 HOURS disaasa or condition resulting in death) Examiner Cerebellar Uncal
Dua to (or as a consaquance of): physicien end s the burial-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceuse (Disease or Injury that Initiated evants rasulting in death) Last HemorRhage · INTRACRANIAL Physician/Medical 8 USB 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings available prior to completion of ceuse Completed 24a. Was an autopsy ate has bage 2 s 1 Yas 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physician: funeral director, 25. Was casa rafarrad to medical Be 26. Place of Death (Check only ona) axaminar? Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After 1 Netural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and mennar as stated.

Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, daeth occurred at tha tima, date end plece, and due to the cause(s) and mannar statad. 29a. Certifian Medical 29b. Signature and titla of certifian 29d. Data signed (Month, Day, Year) 29c. Licansa number MARCH 12, 1999 ause of deeth (Item 23a) (Type, Print) AlberT Romanosky 9000 FRANKlin SEUARE DR. BATTIMORE, MARYLAND 21237 31. Data filad (Month, Day, Yaar) 32. Ragistrar's Signatura Registrar **DHMH 16 Rev 6/95**

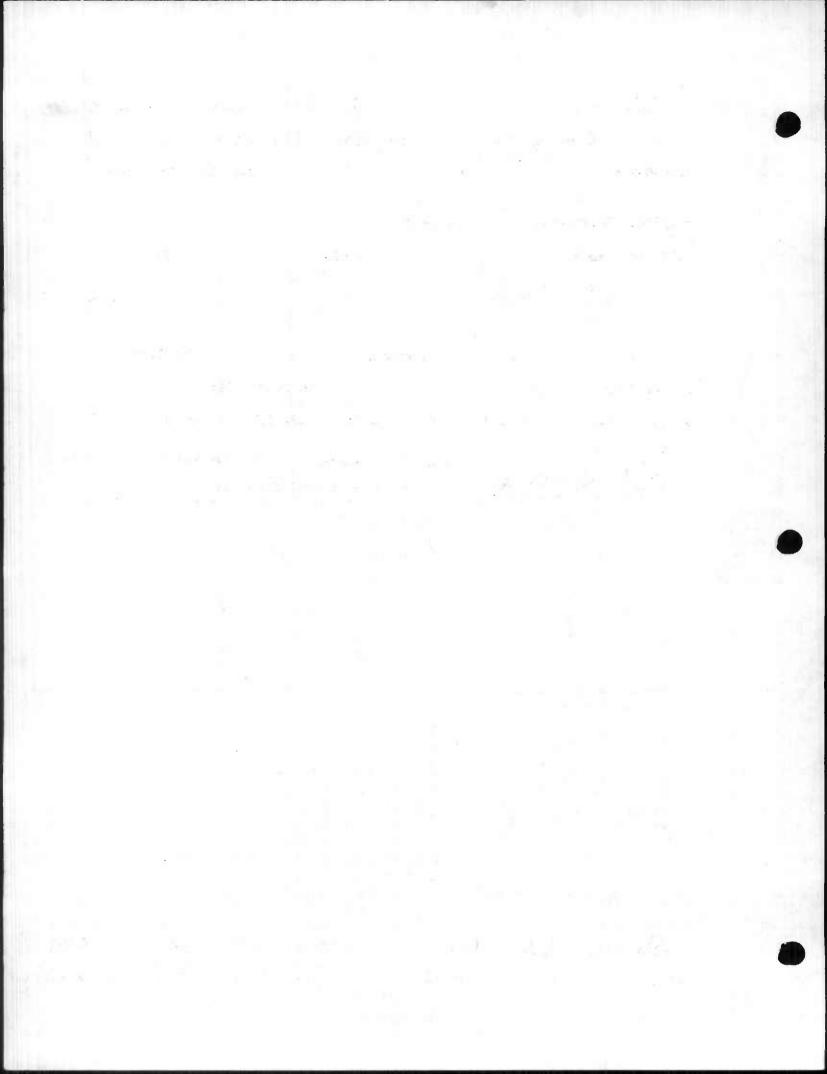
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 925 1999 ingenia 1 graen larch 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fapility Mame (If not institution, give street end number) Hysilal NA Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Sociel Security Number 6. Sex 7. Age (fn yrs. last birthday) 1 M ANTE Months Deys Hours 69 220-22-4993 MD Usuel Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Md NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 2937 Walbrook Avenue 21216 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Yeer or Detes: 14. Race - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 12th Grade Practical Nurse Dr. Malone Office 17. Father's Nama (First, Middla, Last) 18 Mother's Name (First Middle Maiden Sumema) Mufford E. Miles Esther Lennore Miles 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 2937 Walbrook Avenue Baltimore, Maryland Walter Miles 20b. Pieca of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 Durial 2 Cremetion 3 Removel from State Cem. 03-17-99 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Kings Mem. Pk. 22. Name end Address of Fecility 21 Signature of Funeral Service Licensee Baltimore, Maryland 21202 Bemard WM.C.March FH 1101 E. North Avenue mare 23a. Pert1. Enter the disease, or comproditions that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or haart failure. List only one ceuse on each line. Approximate Intarvel Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in daeth) Sephanna Dua to (or es a consaquanca of): RESPIRATORY FAILURE. Sequentially list conditions, if eny, laading to immediate causa. Entar Undarlying Ceuse (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as e consaguanca of): OBSTRUCTURE MISTRSE Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown lung CA 24b. Wara eutopsy findings evaileble prior to HYPENTEUSION 24a. Wes an autopsy completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical exeminer? 26. Plece of Deeth (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatienf 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Examiner

Physician/Medical

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27. Menner of Deeth

Naturel

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29a, Cartifiar

Physician

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Examiner

Funeral

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Pages 1 and 2 should be filed nent of Health and Mental Hygid int: If Item 27 Is marked other.

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Director

Funeral

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physician and s the burial-trans 88 usa signed by the a

page 2 s certificate funeral director. Aftar this

P.O. Box 68760. Division of Vital Records, Hospital or Attending Physician: after death. To the Hospital or Atterwithin 24 hours after der To the Funeral Director completally filled in by the

State Registrar

31. Dete filed (Month, Dey, Yeer)

29b. Signeture end title of cartifier

5 Pending

investigation

6 Could not be datarmined

V. MOEHBELL, MO MAR 1 6 1999

30. Nema end address of person who completed cause of death (Itam 23a) (Type, Print)

JANET V. MOGREBLE, MD

32. Redistrar's Signature person

28b. Tima of

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the causa(s) and mannar es stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, dete end pleca, and due to the cause(s) and menner stated.

29c. License number

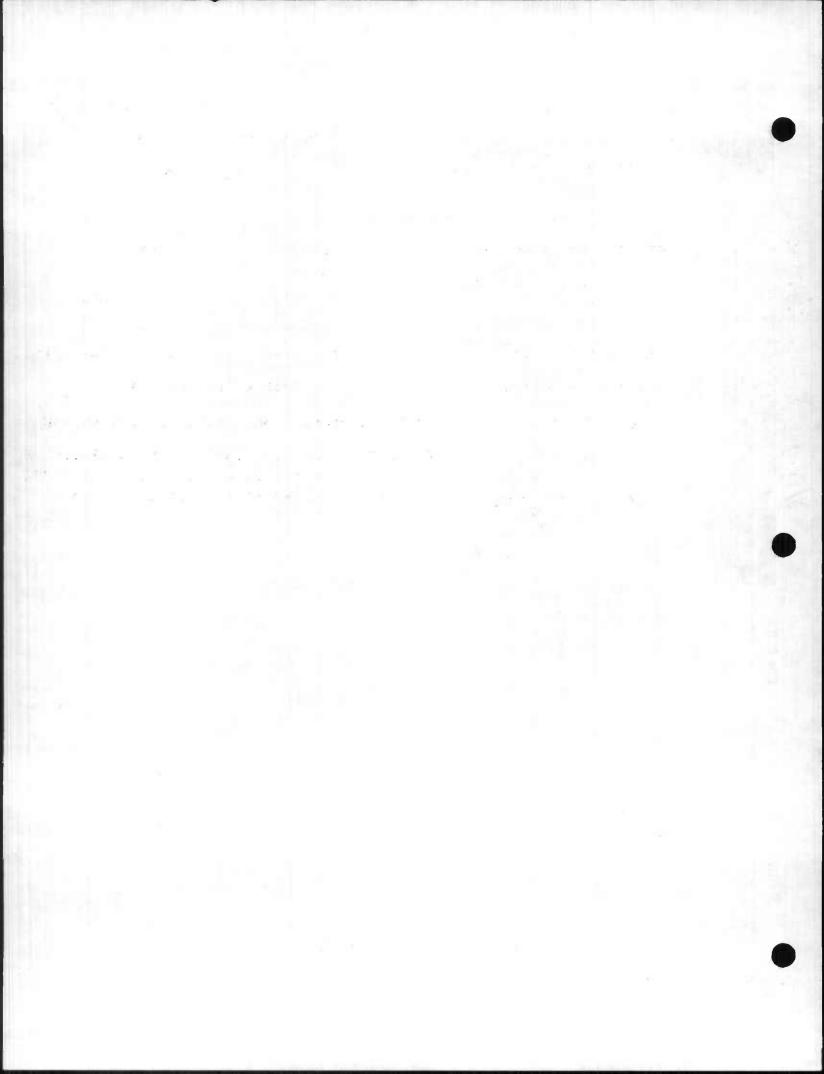
1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Day, Year)

BON SECOURS HONFITAR, FOR W. BAITIMONE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Mental Hygiene Output Department of Health and Hygiene Output Department of Health and Hygiene Output Department of Health and Hygiene Output Department of Health and Hygiene Output Department of Health and Hygiene Output Department of Hygiene Output Department of Health and Hygiene Output Department of Hygiene Outpu Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedant's Nama (First, Middle, Last) FAYE 5:50 PM VOLK 99 MARCH 12 4b. City, Town, or Location of Daath 4c. County of Deeth 4a Fecility Nama (If not institution, give street end number) BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 7, 10 5. Social Security Number 9. Birthplece (State or Foreign 1 ☐ M 3/57F 1912 215-34-8026 RHODE ISLAND Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD BALTIMORE OWINGS MILLS 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 28 ENGLEFIELD SQUARE 21117 USA 14. Raca - American Indian. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck, White, etc. 1 Yas 2 You If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 N Specify: WHITE 3 XVidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highest grade complated) Elementary/Secondary (0-12) Coltega (1-4or 5+) MAY COMPANY 12 SALES CLERK 18. Mothar's Neme (First, Middle, Meiden Surneme) 17. Father's Nama (First, Middla, Last) HARRY BELLIN ALICE LEVIN 19b. Malling Addrass (Straet end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 28 ENGLEFIELD SQ; OWINGS MILLS, MD 21117 HERB DAVIS/ SON IN LAW 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Byrial 2 Cremetion 3 Removel from State BALTIMORE, MD HEBREW YOUNG MEN 3-14-1999 SOL LEVINSON & BROS, INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208 Approxime caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest. Approximation and fine. 22. Name and Address of Fecility Approximete tntervel Betwean Onset and Death Immediete Ceuse (Final disaase or condition resulting in daeth) . ISCHEMIC HEART DISEASE YEARS Due to (or es e consequence of): EDEMA PULMIONAR-1 Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cousa (Disaesa or injury that initiated evants rasulting in deeth) Lest Dua to (or es e consequence of): RENAL INSUFFICIENC 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Uhiknown 24b. Wera eutopsy findings evellable prior to completion of cause of daath? 24e. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 Tyas 2 No 25. Wes cese referred to medicel exeminer? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 Na Inpatiant 2 □ ER/Outpetient 3 □ DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 1 Naturel 5 Pending

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Examiner Physician/Medical þ Completed Be To funeral

Certification:

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

ion 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Med cal Examinar must be notified at

should be filed within 72 hours effer and Mental Hygiene.
Imprisely, or Italian "natural", or Italian

Parmit Pages 1 and 2 sho Department of Heelth and M Important of Heelt

Physician /Medical

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Baltimore, Maryland 21215-0020

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Division of Vital Records. certificate has b After s after death. filled in by

> State Registrar

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K.S.RAO. MI.D.

29c. License number D 43462

154 Certifying Phyaician: To the best of my knowladga, deeth occurred et tha tima, data end piece, and due to tha causa(s) end manner as stated.
2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, daeth occurred et the time, date and place, end due to the cause(s) and menner statad.

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Dey, Year) MARCH 12, 99

Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of parson who complated causa of death (Item 23e) (Type, Print) K. S. R.A.O. M.D.

HOSPITAL CENTER, RANDALLSTOWN, MD NORTHYLEST

28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Spacify)

31. Dete filed (Month, Day, Year) 32. Registrer's Signeture .-MAR 16

investigation

6 Could not be datarmined

2 Accident

3 ☐ Suicide

29a. Cartifian

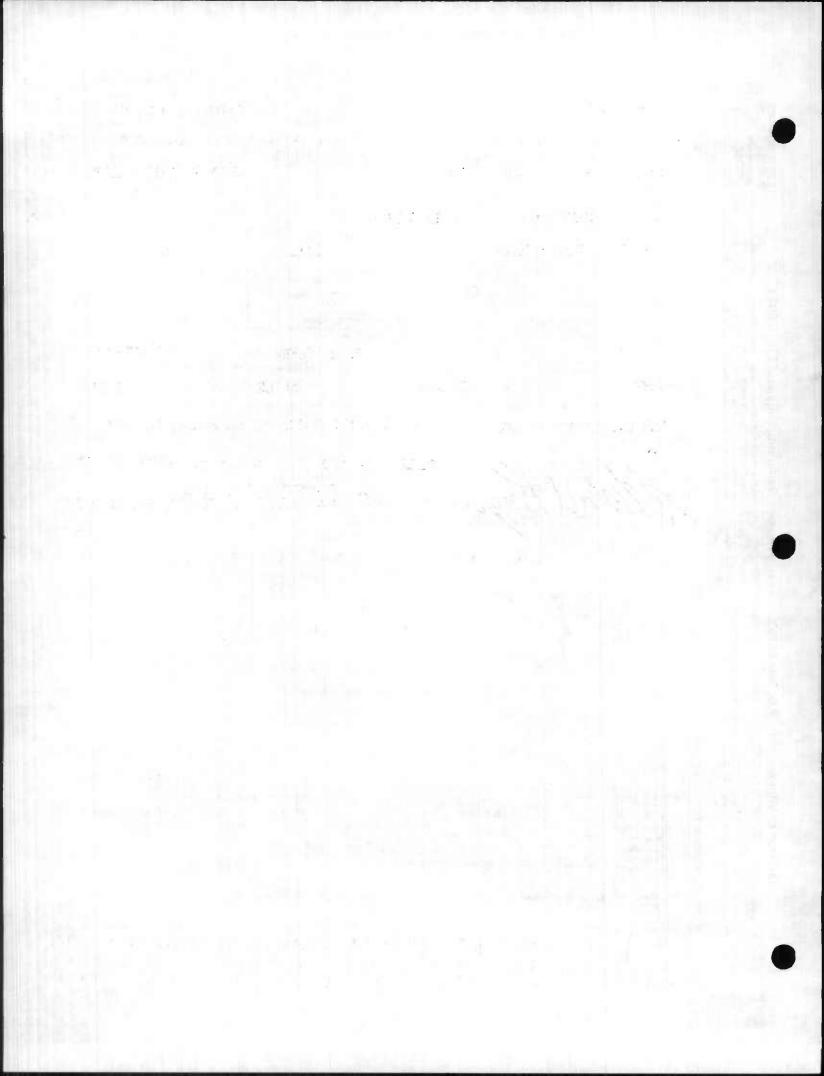
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(Check only one)

29b. Signature and titla of certifier

24 hours

To the Hosp within 24 hor To the Fune completely fi

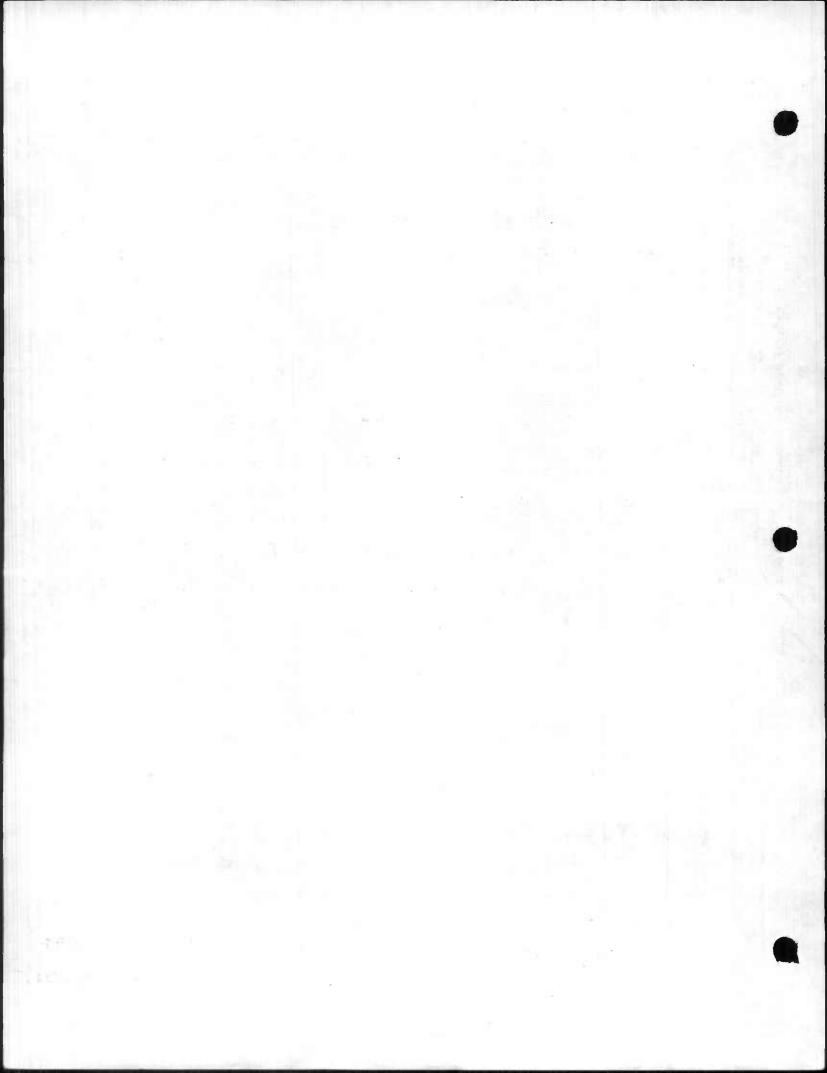


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State of Maryland / Department of Health and	Mental Hygiene

Certificate of Death Reg. No. 1. Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Richard E. Webb, Sr. March 13, 1999 8:30 pm. /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 846 Nabbs Creek Road Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys TØM 2□ F 81 Director May 06 1917 Maryland 212-09-7355 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Anne Arundel Co. Md. Glen Burnie 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 846 Nabbs Creek Road 21060 "natural", or hams 23s USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puerlo Rican, atc.) 14. Race - American Indien, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be illed within 72 hours after Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or its any injury or other traumatic event, the Medical Examines 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: à 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Cross and Elementary/Secondary (0-12) Collega (1-4or 5+) Supervisor 0 Blackwell 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) å Martin Webb Nettie Haughston 19a. Informent's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Webb, Jr. 846 Nabbs Creek Road, Glen Burnie, Md. 21060 (Son) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 3/17/99 Brooklyn Park, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility
McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122 23a. Pert1. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical CONGESTIVE HEART FAILURE Examiner Dua to (or as a consequence of). ARTBRIOSERLEROTIC CARDIONASCULAR physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. FIBRILLA TION 1 Yee 2 No 3 Probably 4 Williams MRIAL à 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 Yes 25 No 1□ Yas 2□ No Division of Vital or Attending Physician; 8 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 Yes 2 100 Other: 4 Nursing Homa 5 Assidence 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No death. ie Hospital or Attendi n 24 hours aftar death he Funerel Director: A pletely filled in by the f investigetion 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Piece of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et tha time, date end pleca, and due to the cause(s) end menner steted. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21776 Mo 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) P- MUMORA 3001 S. HANOVER ST. BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrer's Signetura State MAR 1 6 1999 Registrar

DHMH 16 Rev 6/95

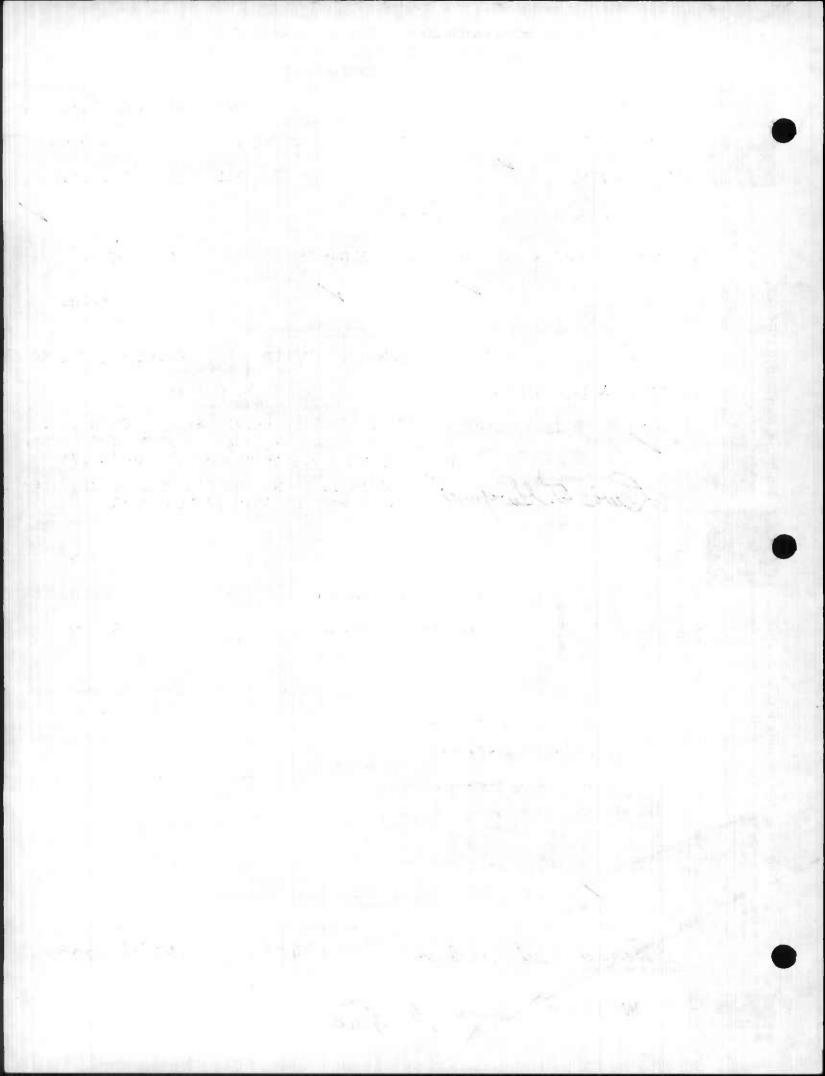


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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Department of Heelth and Mental Hygiens. Department of Heelth and Mental Hygiens. Important: If Item 27 is marked other than "nature any injury or other traumetic event, inc Moderal once. To Be Completed		Trans Watson		560		HE Alama	-DA A	BALLINUK, D	LN 323
		20a. Method of Disposition	20		Disposition (Na crematory or		Date	20c. Location - City	
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any ir		21. Signature of Funeral Service License	100		52 4 0 BB1	nd Address of Facility REA STERS HOWER	TOWN CO	AD - MA	mi A
		23a, Part I Enter the disease, or comp	lications that caused the cone cause on each line.	leath. Do no	t enter the mo	de of dying, such as card	iac or respiratory a	arrest,	Approximate Interval Between
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		27. Manner of Deeth	28e. Date of Injury	28b. Tin		28c. Injury et Work?		how injury occurred	эвсту)
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orector: After this in by the funeral di	ertificati	4 Homicide					ne and due to the	causals) and manner	an atatad
orector: After this in by the funeral di	dical Certification:	29a. Certifier 1₽ Certifying Phy	alcien: To the best of my l nar: On the basis of axam and mannar stated.	knowledge, o ination and/	leath occurred or investigation	at the time, date and pla n, in my opinion, death oc	curred at the time,	date and placa, and d	ue to the cause(s)
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death MARCH 11, Dey 1999 7:30 A.M EDNA MAE WYETH 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) JUNE 1, 1904 5. Sociel Security Number 9. Birthplece (Stata or Foraign 7. Age (In yrs. last birthday) 6. Sax 1 ■ M 2 A F Months Deys Hours PENNSYLVANIA 94 220-10-8820 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location SEVERN 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 21144 UNITED STATES Race - Amarican Indian, Black, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Yeer or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry College (1-4or 5+) BOOKKEEPER HOME IMPROVEMENT 12

29c. License number

D39037

ANNAPOUS MO

21061

Approximate Intervel Between Onsat and Death

2 DAYS

24b. Were eutopsy findings evailable prior to

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

3-11-99

DOUGLAS S MITCHELL MO

r than "natural", or items 23s or 28a-f show the Medical Examiner must be notified at filed within 72 hours after altimore, Maryland 21215-0020 Hygiene. permit. Pages 1 and 2 should be file Department of Health and Montal Hy Important: If them 27 is marked other any Injury or other traumatic event.

Physician

/Medical

10e. Stete

Examiner

Funeral

Director

the Mary

É

Physician /Medical Examiner

that the deeth certificate be executed

P.O. Box 68760,

Records,

Division of Vital

physician and s the buriel-trans 98 5 signed b page 2 certificate Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certific funeral director, io by

MARYLAND ANNE ARUNDEL Director 10e Street and Number 8385 WB&A RD. Funeral 11. Maritel Stetus 1 Never Married 2 Married by 3 Widowed 4 □ Divorced Completed (Specify only highest grede completed) Elementery/Secondery (0-12) 17 Fether's Nama (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) 86 ELIZABETH FOUSE JAMES H. SMITH 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 8385 WB&A RD., SEVERN, MARYLAND 21144 PATRICIA J. BERARDINO/ DAU. 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete MARCH 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete BARREN RUN CEMETERY 16,1999 SMITHON, PENNSYLVANIA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signah o of Funbral Service Licensae 22. Nama end Address of Fecilit KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, 0 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart feilure. List only one cause on each line. Immediete Ceuse (Final diseasa or condition resulting in deeth) · PNEWMONIA - ASPIRATION Due to (or es e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA þ 24e. Wes an autopsy performed? Completed DECUBITUS OLCURS 1 Yes 2000 Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred Naturel 5 Pending NIA 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the causa(s) end manner stated.

DHMH 16 Rev 6/95

State

Registrar

To the Hosp within 24 hou To the Fune completely fi

29b. Signature and title of certifiar

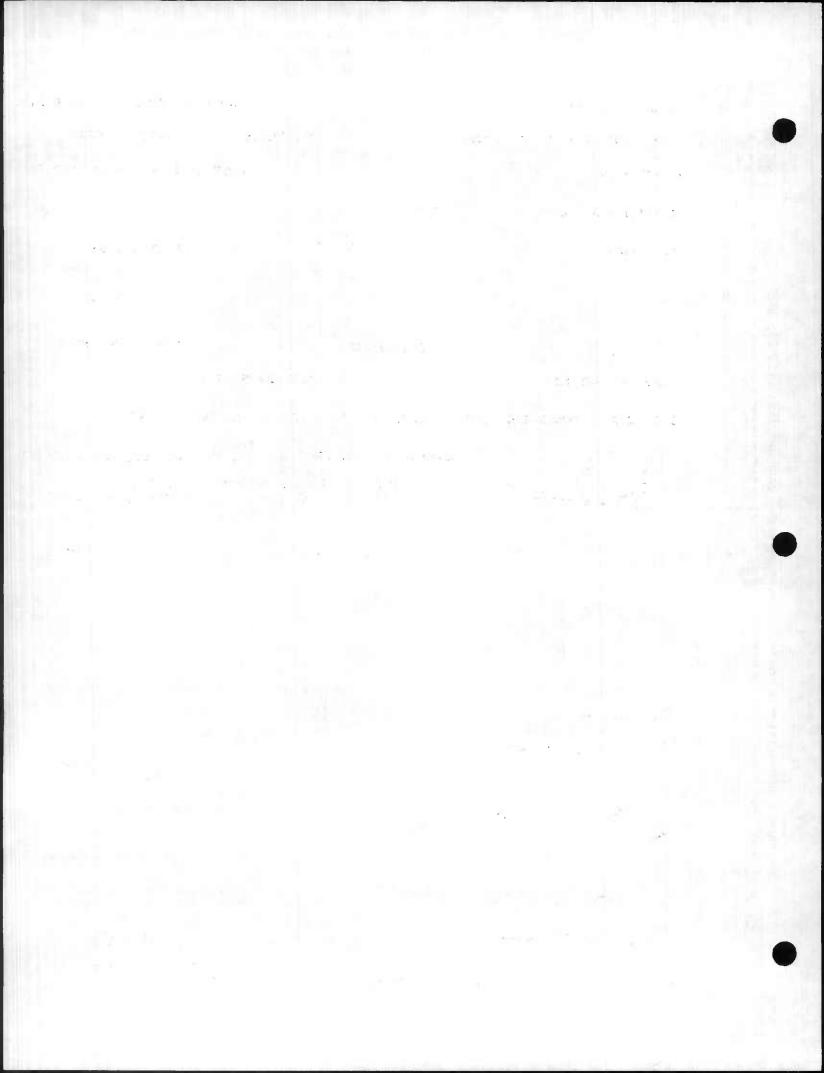
ANNE ARUNDEL 31. Date filed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MAR 1 6 1999

MEDICAL CENTUR

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 1, 1999 Alice Elizabeth Younger 3:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Bon Secours Hospital Baltimore If Under 1 Year If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 💢 F 85 Yrs. 214-20-6967 April 13, 1913 Maryland Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 No Yes 2 No Directo Maryland N/A Baltimore 8 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or flams 23s or 527 Lucia Avenue 21229 USA Funeral 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 72 hours sher 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home pernit. Pages 1 and 2 should be liled vi Department of Health and Mental Hygie Important: if Itsm 27 is marked other I any injury or other treumadic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 88 George T. Holland Mary Irene Reinhardt 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louis E. Younger / Son 527 Lucia Avenue, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Bonal 2 Cremetion 3 Removal from State 5 ☐ Other (Specify) 4 Donation 13/4/99 Metro Crematory Baltimore, Maryland 22. Name end Address of Fecility
Hubbard Funeral Home, Inc. 21. Signature of ineral Service Licens 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Respiratory Failure Examiner Due to (or es a consequence of): Examiner Pneumonia physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Chronic Obstructive Pulmonary Disease Physician/Medical Due to (or es e consequence of): attending p 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 94 signed by ti 1 Yes 2 No 3 Probably 4 Unknown Dehydration: Urinary Tract Infection þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen page 2 s hes 1 Yes 2 No 1 ☐ Yes 2 ☑ No certificate Division of Vital director. Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: or Attending 1 [XNatural 5 Pending investigation after death.
Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in edical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certified 29c. License number 29d. Date signed (Month, Day, Year) Main , mD D-15698 MARCH 16, 1999 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) MARCOS GALICIA, M.D. - BON SECOURS HOSPITAL - 2025 W. FAYETTE STREET - BALTO., MD

State Registrar

31. Date filed (Month, Day, Year)

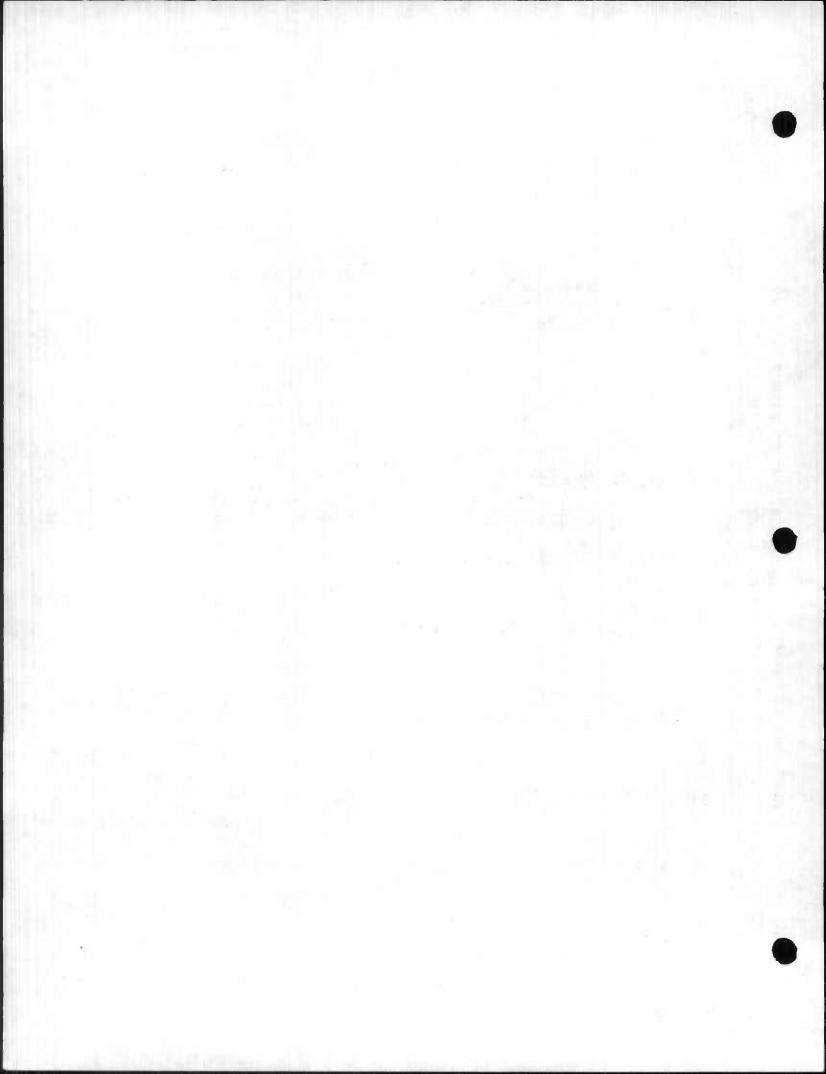
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32. Registrar's Signathre

DHMH 16 Rev 6/95

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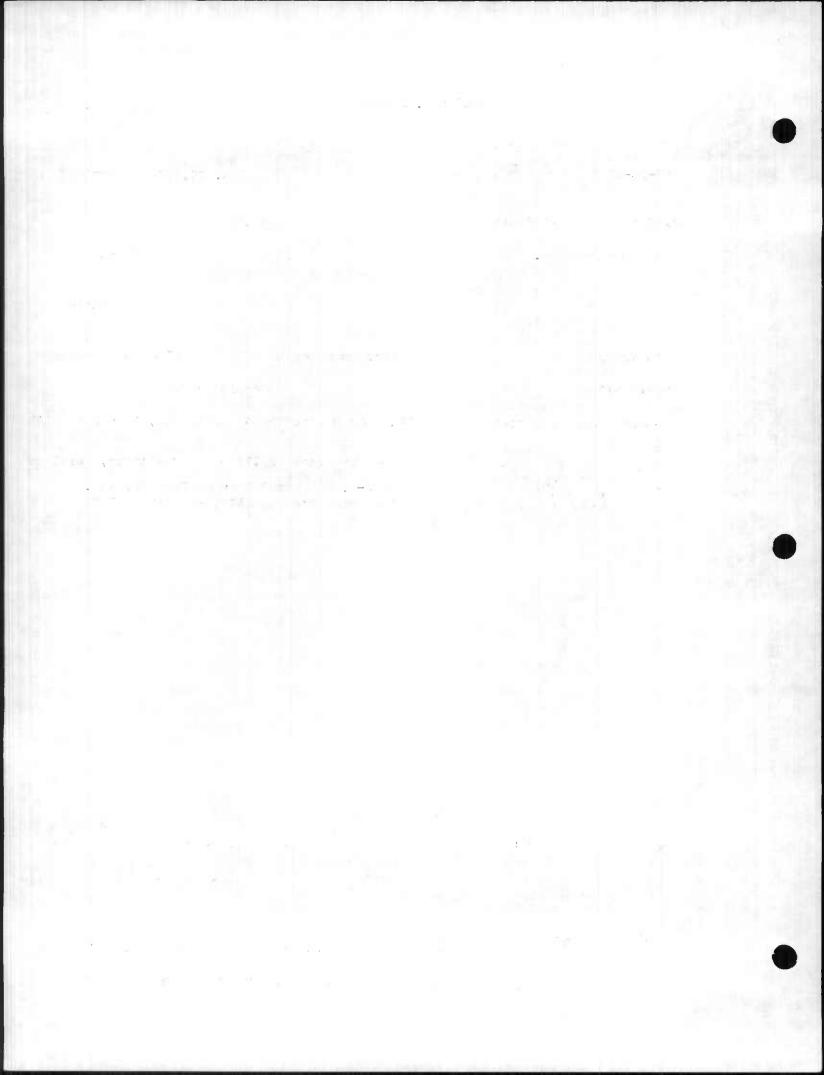


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State of Maryland / Department of Health and Mental Hygiene

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Physicia	in	1. Decedent'a Nama (First, Middla, L.		dolyn V	W. Za	wodny			2. Data of Daath Month	Day	Yaar	3. Tima of Death		
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		Ramona Krepka/I	Daughter		781	8 Old Ha	arford H	Road	Baltin	more, l	Maryl	and 2123		
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Dellimor permit. Pages Department of I Important: If Its Iny injury or o		1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		10		wn Cemet		2/17	/1999	Baltin	more	Maryland		
Daltimore, bemit. Pages 1 ar Department of Hea mportant: If Item in highly or other bids.	-	(/)	100000	***			-	3/,1/,	/1000	Darci	more,	naryrana		
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		raluk	11-sen	und) 7	7922 Wise	e Ave I	Dund	alk, Ma	ryland	212			
		23a. Part f. Entar tha disaasa, or con shock, or haart failura. List only	recitions that caus y one cause on each	ied the death	not an	tar tha moda of dy	ring, such as ca	rdiac or	raspiratory arra	st,		Approximata intarval Batween		
• Physician				1							1	Onset and Death		
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l or Attend effer death Director:	#	3 Sulcida 6 Could not datarmined	d Zoa. Place of	Injury - At hom atc. (Spacify)		raat, factory, office	8.	28	3f. Location (Str City or Town,	eet and Numl Stata) Ri	dae I	Route Number, Road at		
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To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	edical	(Check only one) Medical Exa	minar: On the basis and mannar		n and/or in	ivastigation, in my	opinion, daath	occurred	at tha tima, da	na and place,	and dua t	o ina ceuse(s)		
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death HELEN March ZESKIND 4a. Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Hondar 1 Year If Under 24 Hrs. 8. Date of Birth SELFT, Box Year 17 5 Social Security Number 7. Aga (In yrs. last birthday) 6. Sax 9. Birthplaca (Stata or Foreign 1 M 20 F 215-03-9973 81 MARYY AND Yrs. Usual Rasidance of Dacedant 10a. State 10c. City, Town or Location PIKESVILLE 10d. Insida City Limits BALTÍMORE MD 1 ☐ Yas 2 No 10q. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 725 MT. WILSON LANE APT. 825 21208 U.S.A. 12. Was Decadant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Specify: White, 1 Yas 27 No if Yas, Give Yaar or Datas: 1 □ Navar Married 2 □ Married 1 Yas 2 No 3 Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-49r 5+) RETAIL OWNER FURNITURE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) ROBERT CUMMINGS ROSENBLOOM 19a. Interment's Neme/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ROBERT ZESKIND/SON 5135 NEWPORT AVE. BETHESDA MD. 20816 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval trom Stata ARLINGTON CEMETERY CHIZUK 3/14/99 BALTIMORE 4 ☐ Donation 5 ☐ Othar (Specify) AMUNO CONGREGATION 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onset and Death Tillacrama immediata Causa (Finel disaasa or conditto rasulting in daath) Dua to (or as a consequence of): Sequentially list conditions, if any, leading to Immediata cause. Enter Undarlying Cause (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hy reilen pur 24b. Wara autopsy tindings availabla prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 Yas 2 No 25. Was casa referred to medical axaminar? 28. Piace of Deeth (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Deta of Injury (Month, Day Year) 28b. Tima ot Injury 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 Yas 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Piaca of Injury - At homa, tarm, straat, tactory, office building, atc. (Specify)

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Certification:

Medical

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(Check only one)

29b. Signature and titla

29e. Certifian

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises.

attending physician and for use as the burial-transigned by the a d be detached f has

Records, P.O. Box 68760 the death certificate be Division of Vital al or Attending Physician: T s after death. Is Director: After this certificat ed in by the funeral director, p filled In by

24 hours a Funeral D within 2 To the F

State Registrar

MM

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

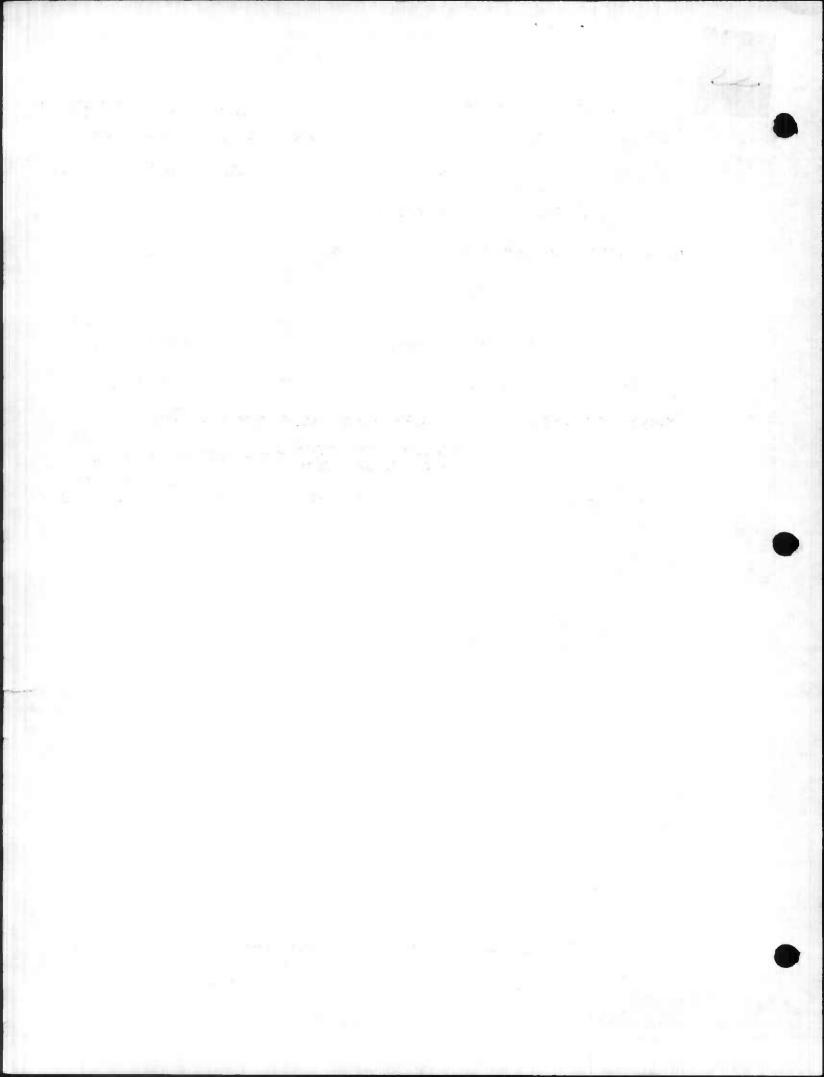
Manual Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) March 11, 1399

30. Name and edgless of person who completed cause of deeth (Item 23a) (Type, Print) IMPERIM

31. Data tilad Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Ray 6/95



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/Medic	_		AEL ALLE					th Oh Town	MARCH	1	1999	2215	P
Examin	er			e street and number)				4b. City, Town, or		1 4c. Count	ly of Death		
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marked other imatic event,	2	UNK	KNOWN					MAR	RLENE A	LLEN			
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itsm 27 is other trai		MARLEN	E ALLEN	(Mother)	1	814 Hop	e S	t. Balt	imore,				
* *		20a, Method of Di	•	Removel from Stete	20b. Place came	a of Disposition (Na etary, cramatory or	ame of other pla	ca)	Date	20c. Location	- City or To	own, State	
			5 Other (Special		CE	DAR HIL			3/18/99				•
Important: any injury pace.		21. Signature of F	Funeral Service Lice	nsee C	1	22. Name a	and Addre	ess of Facility 1	09 West	t Nort	h Ave	enue	
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State Registrar

31. Date filed (Mo

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

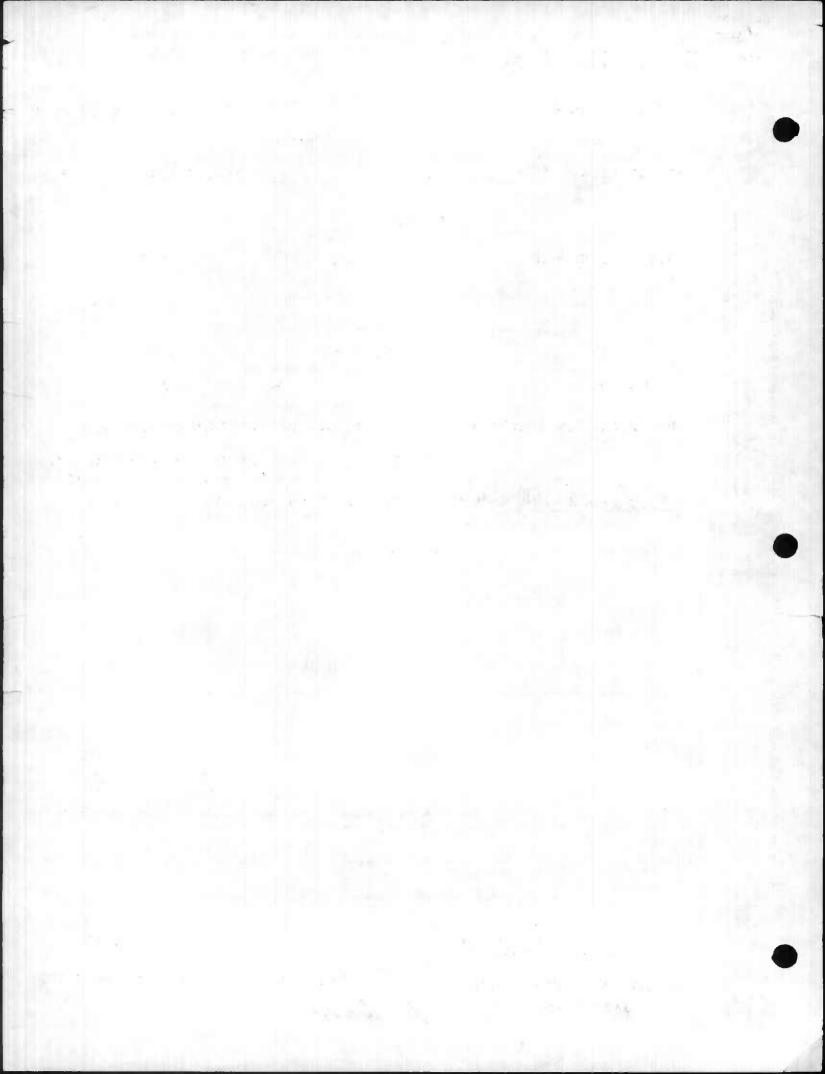
29c. License number

O.C.M.E

29d. Date signed (Month, Dey, Year)

MARCH 12,1999

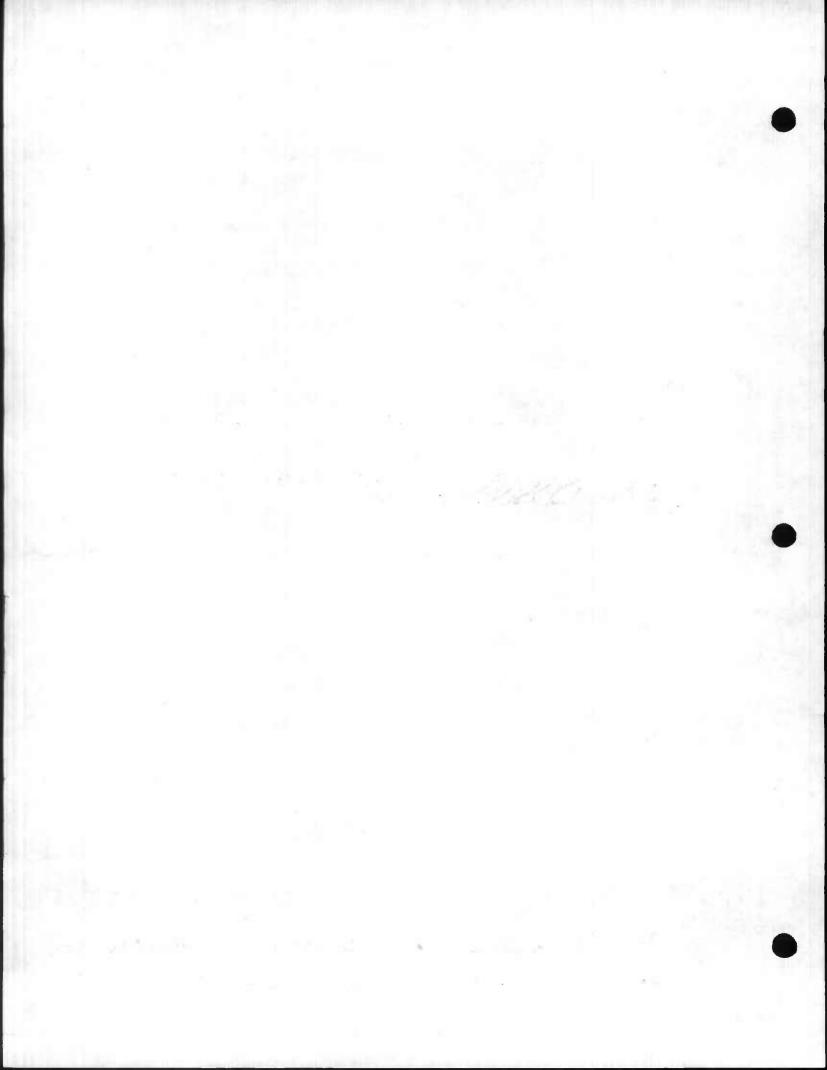
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Stanley Charles Andrick March 13, 1999 6:00 P.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Hours Months Yrs Director 182-12-4003 76 March 30, 1922 Usual Residence of Decedent death with the Maryland 10a State 10b. Count 10d. Inside City Limits ahow 10c. City. Town or Location 7 is marked other than "natural", or itema 23a or 28a-f aho treumatic avent, tra Madical Examiner must be notified at 1 ☐ Yes 2 XNo Director Md. Harford Forest Hill 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Spencer Cr. 21050 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Ves 2 No If Yes, Give Year or Dates: WW-II 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit, Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene, Important: If Item 27 is marked other than "na any injury or other treumatic avent, the Medit and an experiment." Elementary/Secondary (0-12) College (1-4or 5+) Mass Transit Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Anthony Andrick Antoinette Dransite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Christine S. Fitzgerald/dtr. 123 Spencer Cr. Forest Hill, Md. 21050 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 3/18/99 Eldersburg, Md. 21. Signature of Funeral Service Licer 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical <Tw. meumones Examiner Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be execu Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings 24a. Was an autopsy Completed available prior to completion of cause of death? performed? has 1 Yes 2 No 1 Yes 2 No Division of Vitai To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetien1 3 DOA 1 Yes 2 No Other: Nursing Home 5 Residence 8 Other (Specify) 2 this 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred edicai Certification: After 5 Pending investigation Neturel after death.

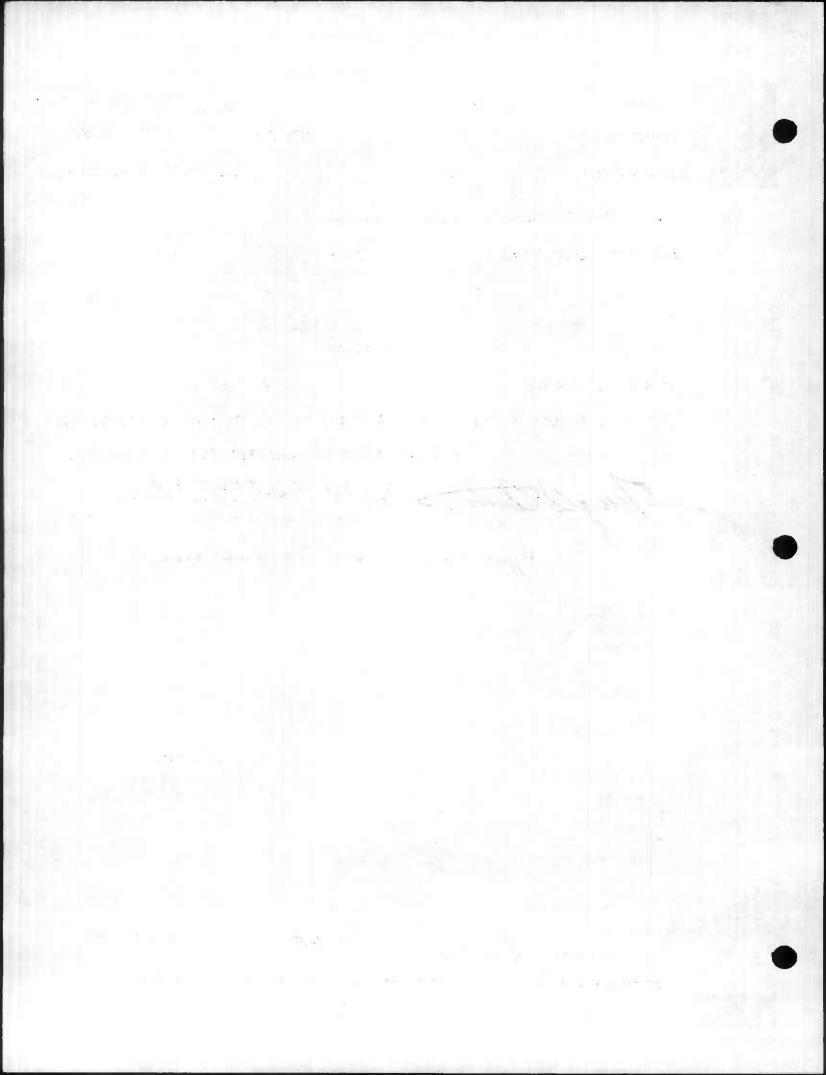
Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie March 15, 1995 03229 pish 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAV. DS. UNN morpha. 615 W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print In Black Indelible ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygien 9 0827

					Ce	rtificate	e of	Death			Reg. No.		
Physician /Medical	1. Decedent's Nar ANNIE	me (First, Middle, L		NOLD						2. Date of De Month MARCH	Day	Year 19	3. Time of Deeth 0656 AM
Examiner		(If not institution, gi GEORGES I						4b. City, To CHEV		ocation of Deet		y of Death	EORGES
Funeral Director	5. Social Security 578-66-	9753	Sex 1 M 2 F	7. Age (In yrs. le 5 4	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	8, 1943	9. Birth	place (State or Foreign pto) AROLINA
Maryland a-f show iffied at	Usuel Residence 10a. State MD	10b. County PRINCE	GEORGE		Town or Lo		'S						10d. Inside City Limits 1 ✓ Yes 2 ☐ No
3a or 28	10e. Street and N 908 CY	umber PRESSTRI	EE PLAC	CE		10f. Zip	Code 74	3			10g. Citizen of USA	Whet Cou	ntry?
72 hours after death with the Maryland 72 hours after death with the Maryland natural; or items 23a or 28a-f show dreal Examinat must be notified at eted by Funeral Director	3 Widowed	rrled 2 Merried	12. Wes Dec Armed Fo 1 Yes If Yes, Gir Year or D	2 No		Was Deced If Yes, spec	ify Cub	en, Mexica	n, Puerto	ecify Yes or No Ricen, etc.)	Bla	ce - Ameri ack, White	
within than than	(Specific Specific Sp	15. Decedent's E ecify only highest gi condary (0-12)	Education rade completed) College (1-4or 5+)		dent's Usua kind of wor DO NOT us MEMAK		oation during mos d)	st of work	ing	16b. Kind of I	Business/II	ndustry
d 2 should be filed th and Mentel Hygi 7 is marked other traumatic event, I	17. Father's Name	E . ARNO								me (First, Middle, Maiden Surname) A HORTON			
1 and 2 sho Health and P em 27 is ma other traume	JESSE	19a. Informant's Name/Relationship (Type, Print) JESSE J. ARNOLD (SON) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 908 CYPRESSTREE PLACE, CAP HGHTS, MD. 207 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State											0.20743
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death certificate be executed to estending physician and of for use as the buriel-transit siclan/Medical Examiner	Sequentially list of if eny, leading to ceuse. Enter Unc Cause (Disease that initiated even resulting in deeth	conditions, Immediate derlying or injury	a. Hyper b c		as a consecutive as a c	quence of):	ohe	Carel	i ova	suur	Disease		
that the death cered by the ettendire deteched for use	Part il. Other sign	ificant conditions	contributing to d	eath but not resu	ilting in the u	inderlying ce	euse gi	ven in Part	I.				to the cause of death?
aw requires as been sign 2 should be										24a. Wa	s an autopsy formed?	24b. V	Vere autopsy findings vailable prior to ompletion of ceuse f death?
F # a O	25. Was cese refe	arred to medical						26 Place	e of Deep	1 □	Yes 2 No	1	☐ Yes 2☐ No
Physician: this certificated director,	examiner?		Hospital:	Inpatient 2	ER/Outpetie	nt 3 DO	A Ot	her _	- 11			ther (Spec	ify)
五年 元	27. Manner of Dea	5 Pending investigation	(Mon	TE impatient 2000 Period 3E DOX 4E Indising non						how injury occi			
tal or Attending rs efter deeth. al Director: After led in by the fune Certification	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location City or To	(Street and Num own, State)	iber or Hu	ral Route Number,
To the Hospital or Attending I within 24 hours eiter deetin completely filled in by the funer completely filled in by the funer Medical Certification.	29a. Certifier (Check only one)	1☐ Certifying P 2☐ Medical Exa	miner: On the b			vestigation,	In my	opinion, de			, date and place	, and due	to the cause(s)
To uthing	29b. Signature en	lenn	1/Ch	uten		(se number .M.E.			29d. Dete sign MARCH		
		chute M.	F				Ba	ltimo	re, l	Marylan	d 21201		
State Registrar	31. Dete filed (Mo	MAR 1	7 1999 J	legistrar's Signat	ture /	9. 1	po	1					



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 MARCH 9, 7:00 A.M RAYMOND L. BELL 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 7416 HINDON CIRCLE APT. 103 (HOME CARE) BALTIMORE 8. Date of Birth (Month, Day, Year) JULY 29, 1908 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) MD 5. Social Security Number XXM 2 F Months Days Hours 90 107-14-4299 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 14 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 6119 JOHNNYCAKE RD. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ဤ No If Yes, Giva Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: AFRO-AMERICAN 3 □Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER OF DUMP TRUCK CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) NOAH BELL CLARA HARDY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LAWRENCE DICKERSON (FREIND) 6119 JOHNNYCAKE RD. BALTIMORE MD. 21207 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlat 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/16/99 LANDSDOWN MD. ZION CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MD.21217 23a. Part1. Enfar the diffesse, or complications that caused the death. Do not enfer the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death · Prostate caremona with Metastasia fmmediate Cause (Final diseese or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet Initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): 23b. Did tobacco usa contributa to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Bestersen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periormed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

98 attending p signed by the a d be detached f or Attending Physician:

aymon

Physician

/Medical Examiner

> Examiner After this

Physician

/Medical

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Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentell Physione. Important: If then 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Edication mans be notified at

Baltimore, Maryland 21215-0020

Physician/Medical þ Completed Be Certification: To

ofter deetl Diractor:

1 Yes 2 No 27. Manner of Death

29a. Certifier

(Check only one)

1 Naturel 5 Pending investigation 2 Accident 3 Suicida

6 Could not be determined 4 | Homicide

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicfan: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) and manner as steted

29b. Signature and title of certifier

29c. License number D26748

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

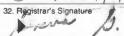
aperou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FALLS RD BALTOMD & 1211 ANILUBEROF MD 4419 31. Date filed (Month, Day, Year)

Registrar

Medical

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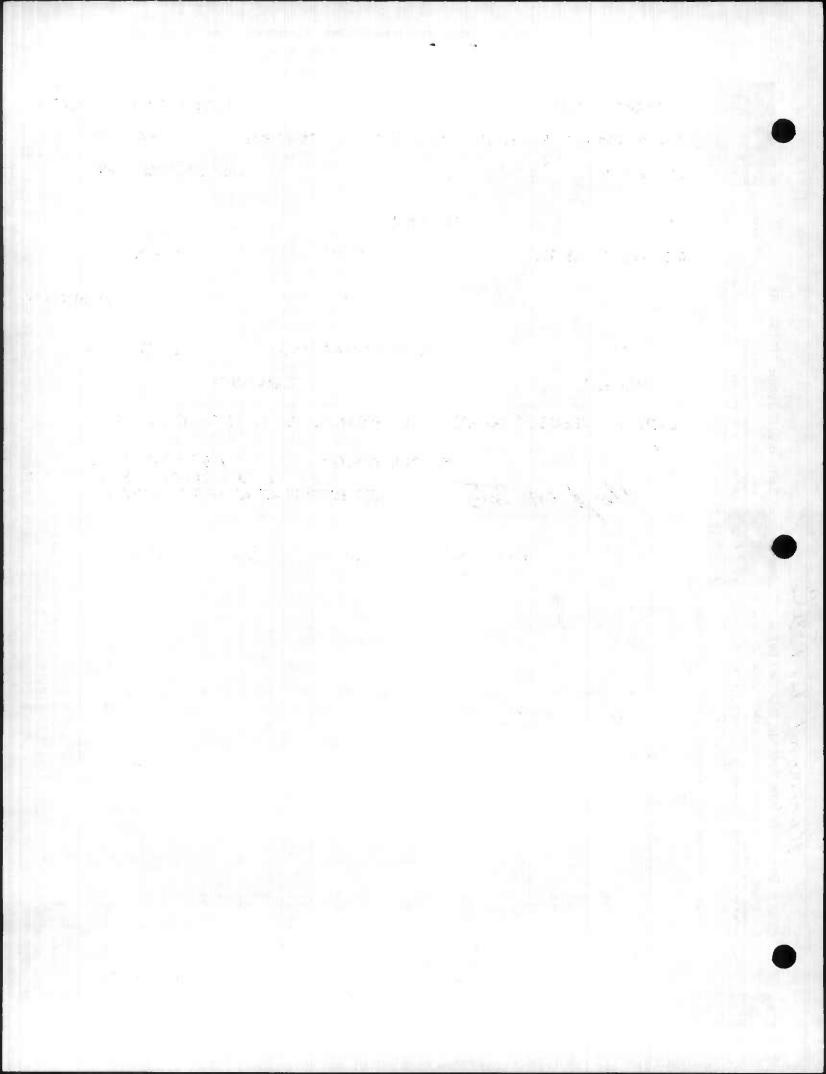
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vaar **Physician** BUSTON ERNEST EL WOOD 11:57 03 89 /Medical 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUAD Apt. 605 BALTIMORE 6800 LIBERTY If Undar 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 5. Social Sacurity Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) 1**∑**M 2□ F Yrs. 59 220-38-9910 12/20/1939 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6800 Liberty Road Apt. 605 21207 U.S.A. 12. Was Decedent Ever in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Nevar Married 2 ☐ Married Black 1□ Yes 2 No à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) News Reporter Broadcasting 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Ernest Elwood Boston Sr. Muriel Washington 19a. Intormant'a Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8 Charles Plaza Apt. 705, Baltimore, Maryland 21201 Selena Boston / Wife 20a. Method of Disposition
1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Othar (Specify) 03/17/99Baltimore, Maryland Metro Crematory, Inc. 22. Name end Address of Facility The Derrick C. Jones Funeral Hm., 21. Signatura of Funeral Servica Licensee 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition rasulting in death) a CONGRETIVE Follure HUBART Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Dua to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Onknown Carownegoly þ 24a. Wes an autopsy performed? 24b. Were autopsy tindings available prior to complation of cause of death? Completed Hypertension 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Rasidenca 8 ☐ Other (Specify) 10 28a. Date ot injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yas 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Plece of Injury - At home, tarm, street, tactory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and menner as steted. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number Jack 021328 ~0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Heights Due Keet, more and 21207

Physician /Medical Examiner be executed physician and the buriel-trens

Funeral

Director

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traumatic event, the Medical Examiner, must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer death v Department of Health and Manial Hygiene. The marked other than "natural", or theme 23a any Injury or other traumatic event, the Medical Examples 200.

Baltimore, Maryland 21215-0020

Box 68760. P.O. Records, Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the Iuneral director,

> State Registrar

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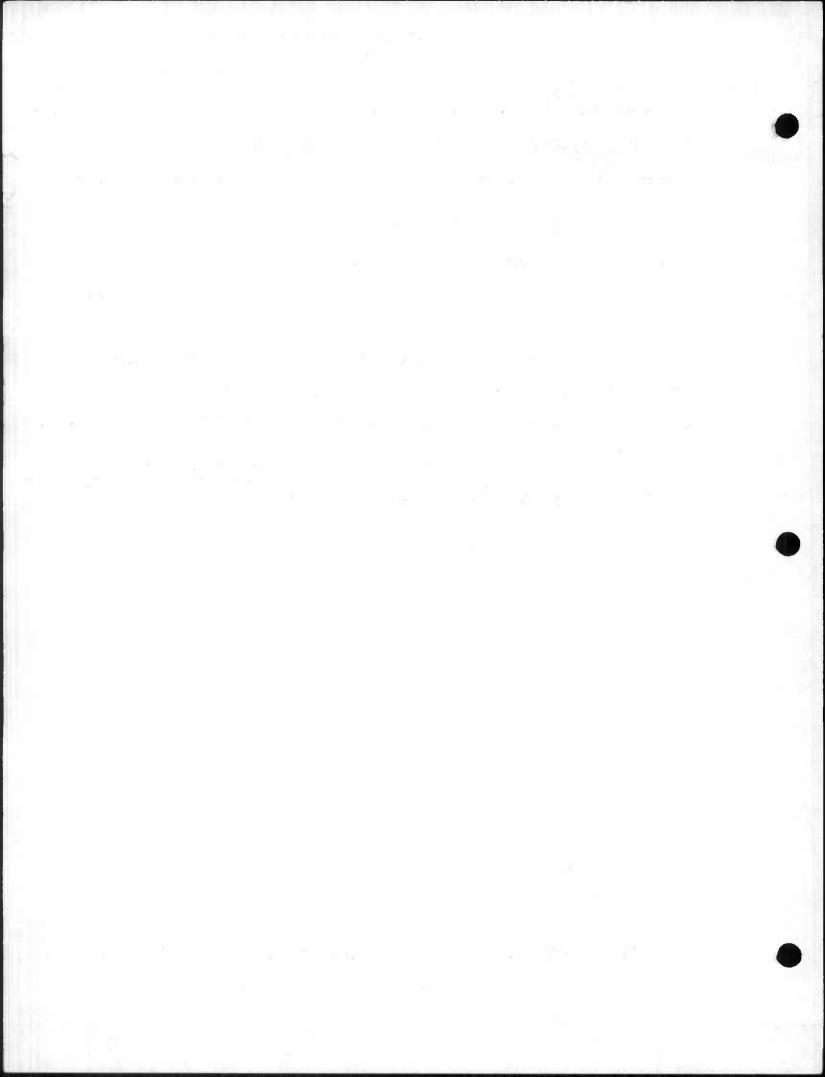
31. Date filed (Month, Day, Yeer)

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32. Registrar's Signatura

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Deeth Day 1999 March 11, 5:30 PM Martin Barry J. Jr. 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, giva street and number) Baltimore Towson 4 Burnbrae Road If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | Months Days 5. Social Security Number 7. Aga (In yrs. last birthday) 1 Q M 2 □ F Yrs. 7-1-1927 Maryland 217-24-8962 Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 ☐ Yes 2 ☑ No Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4 Burmbrae Road 21204 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yas 2 ☐ No If Yes, Giva Specify: White 1 ☐ Yes 2 Ø No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Professional Artist Martin Barry Studios 18. Mother's Nema (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Martin J. Barry, Sr. Tressa Fitzsimmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs Barbara A. Barry (Wife) 4 Burnbrae Road, Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) New Cathedral Cemetery 3-15-99 Baltimore, Maryland 1050 York Road 21. Signature of Funeral Service Licensea 22. Nama and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Ruck Towson Funeral Home, Inc. Towson, Md. 21204 Approximate triterval Between Onset and Death tmmediate Ceuse (Finet disease or condition resulting in death) a. Massive upper GI Due to (or as a consequence of): Small cell Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Dua to (or as a consequence of): onchia Due to (or as a consaquence of): Radiation D057 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the undertying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Paxemi pratory 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2€ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Maturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

physician end the burial-transit The law requires that the death certificate be executed P.O. Box 68760 ettending ph for use es t Division of Vitai Records, his certificate has buildirector, page 2 st this funeral After or Attending ector: 6 Direc

Physician

/Medical

Examiner

Director

Funeral

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Director

Pages 1 and 2 should be filed within 72 hours after death with the Manyland neat of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other transition and the notified all any or other traumatic event, ma Medical Examiner must be notified at

permit. Page Depertment of Important: if any injury or

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29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0020

Houpital of 24 hours at Funerel D within 2 To the To the

State Registrar

30. Name and address of person who completed cause of death (frem 23a) (Type-Frint)

29b. Signature and his bi certifier

31. Date filed (Month, Day, Year) 1999

6 32 Registrar's Signature

14

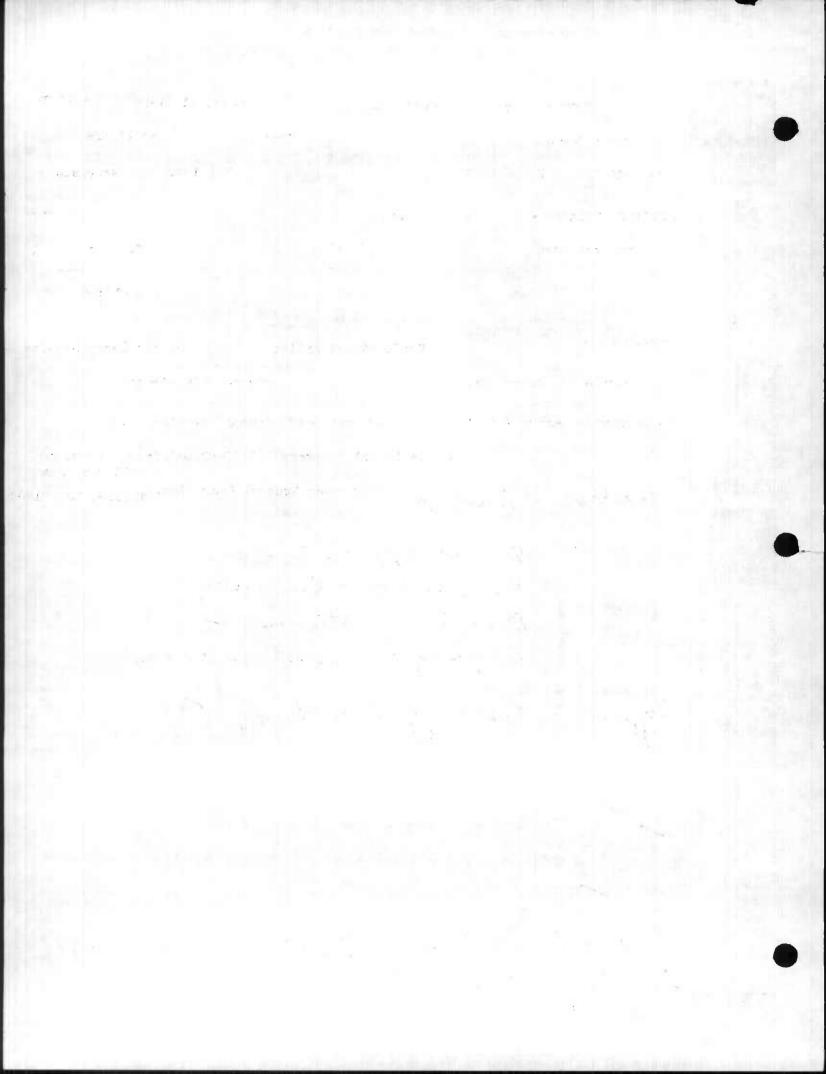
Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted.

29c. License number

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29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth **Physician** Month Month 2.1017 RNESTINE 11+5,1999 /Medical 4e. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Center C Catons VIII e ar If Undar 24 Hrs. 8. Di s Hours Min. (A tredrick BALTIMORE Villa Nursing 7. Age (In yrs. lest birthdey) 5. Sociel Security Number 6. Sex Birthplece (Stete or Foreign Country) 1□ M 20 F Months Deys Yrs. 167-12-4252 GA. Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. N/A 1XXYes 2 □ No BALTIMORE 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? 3935 DUVALL AVE. by Funeral 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Bleck, White, etc. 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: BLACK 3 ☐-Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) -12--0-LIBRARIAN GOVERNMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be CARRIE RAGIN EDWARD B. DAVIS 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ELAINE PINKNEY (DAUGHTER) 3935 DUVALL AVE. BALTIMORE, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other pleca) ROLLING GREEN MEM. PARK 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 3-14-99 WEST CHESTER, PENNA. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funerel Service Licenses 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Batween Onset end Deeth Immediete Cause (Final disease or condition resulting in deeth) STROKE Wearky Due to (or es e consequence of): Examiner Hemorrhage Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequenca of): Hy Pertension Physician/Medicai Due to (or as a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown Dementa by 24b. Were eutopsy findings available prior fo completion of cause of deeth? 24e. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 25 No 25. Wes casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide

Box 68760 P.O. Division of Vital Records, **Funeral**

Director

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Baltimore, Maryland 21215-0020

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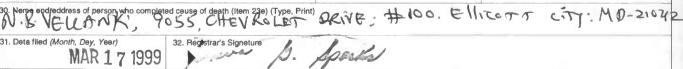
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29b. Signature end title of certifier

29e. Certifier

(Check only one)





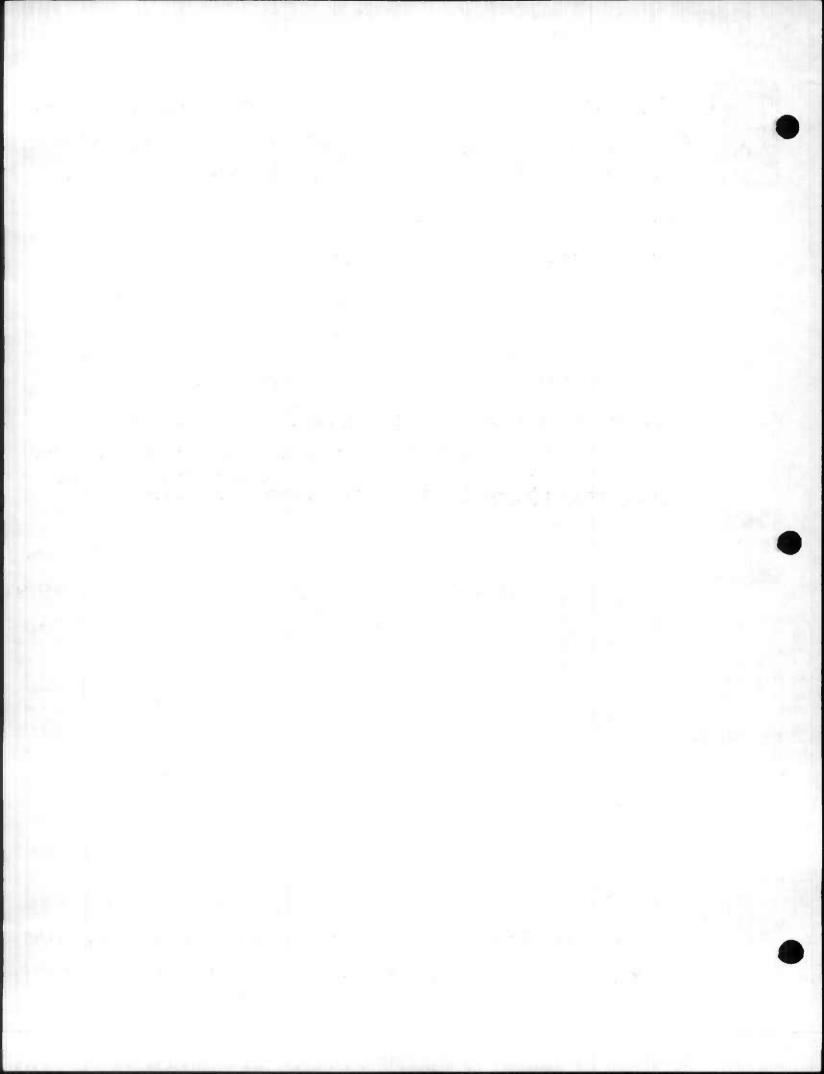
1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end pieca, end dua to the causa(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, In my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.

29c. Licansa number D · 3 0 4 6 9

29d. Date signed (Month, Dey, Year)

March



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	Funeral Director		214-22-4566	Sax 1⊠M 2□F	7. Aga (In yrs. 72	last birthday) Yrs.		Yaar Days	If Undar 24 H Hours M	lin. (Month, De	th ly, Year) 25,1926		olaca (Stata or Foraign oltry) yland
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	23s or 2	rai Dire	10e. Street and Number 7738 North Poin	t Road			10f. Zip C	oda	21219		10g. Citizan of V		
020	be filed within 72 hours after death with the Maryland tal Hyglena. d other than "natural", or items 23e or 28e-f show event, the Medical Examinat must be northed at	by Funeral	11. Marital Status 1 □ Navar Married 2 □ Married 3 ☒ Widowad 4 □ Divorced	12. Was Dac Armed Fo 1 Yas If Yas, Gi Yaar or D	2. IXNo va		Was Dacedai If Yas, specify 1 ☐ Yas 2 €		panlc Origin? , Maxican, Pu Specify:	(Specify Yas or No arto Rican, atc.)	Specify	e - Amaric ck, Whita,	
Maryland 21215-0020	within 72 ho ena. than "natur ine Medical	Completed	15. Decedant's E (Specify only highest gi Elementery/Secondary (0-12) 11 Years	ducation rada complated) College (16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use ratired) Truck Driver				working	16b. Kind of Bu		Company
yland 2		To Be Co	17. Father's Nama (First, Middla, Las Earl Bauer			ILU	CK DII			Nema (First, Middle red Hellr	, Meiden Sumen		Company
	and 2 should laalth and Mar m 27 is merke her traumstic		19a. Informant's Name/Ralationship Mrs. Vivian T.		sworth	24:	21 Mun	ford		Rural Route Numb	on, Mary	land	21047
Baltimore,	permit. Pages 1 and 2 si Department of Haalth and important: if Item 27 is n any injury or other traur ance.		20a. Mathod of Disposition 1		Stata	Placa of Dispo camata <i>ry, cr</i> ai rkwood	matory or oth	ar placa		7/1999	20c. Location -		wn, Stata Maryland
Rail	Depart Import any in		21. Signature of Funeral Service Lice	kles		1		uck	Funera	l Home o: Dundalk,			
,	Physician /Medical Examiner		23a. Part √Enter the disease, or cor shock, or heart failura. List only Immediate Causa (Final disease or condition resulting in death)	nplications that of yona cause on o		th. Do not and	sis	of dying	, such as card	diac or raspiratory a	rrast,		Approximate Interval Betwaen Onsat and Death
8/60,	certificate be axecuted nding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants	b		or as a consec							
BOX 68	ding Ise a	4	resulting In death) Lest	d			quarioo oi).						
7. O.	0 0 %	Physician/M	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	indarlying cau	usa giva	n in Part I.		tobacco use con		the causa of death?
ecords,	aw requi	Completed by									an autopsy prmed?	av.	ara autopsy findings allabla prior to mpiation of causa death?
T m	The ata h	0	25. Was casa referred to medical						26. Piaca of [1 □		1[Yas 2□ No
ion or vit	fing Phys n. After this funeral di	ation: To B	axaminar? 1	28a. Data (Mon	Inpatiant 2 of Injury	28b. Tima o Injury		Othai c. Injury Work	4 Nursin	g Homa 5 ☐ Rasi			()
DIVISION	F # F C	Certification:	3 ☐ Suicida 6 ☐ Could not l 4 ☐ Homicida datarminad	28a. Place	of Injury - At hing, atc. (Spaci	ome, farm, str fy)	raat, factory, o	office		28f. Location (City or To	Straat and Numb wn, Stata)	er or Rura	l Routa Number,
	To the Hospital of within 24 hours all to the Funeral D completely filled it	edical	29e. Certifiar (Check only one) 1 ☐ CertifyIng P 2 ☐ Medicat Exa	minar: On the b	best of my kno asis of axamina ner stated.	owledga, death tion and/or in	h occurred at vestigation, in	tha time n my opi	a, data and pla nion, daath o	ice, and dua to tha courred at tha tima,	data and place,	and dua to	tha causa(s)
	To To Com	M	290. Signature and title of certifier When	M	Cer	~	29c. 1	Licansa 4	number		29d. Data signa Mavu		
	(0)		30. Name and eddrass of person who was a second of the sec	nital,	67	0 1	Print)	ha	ules	St, Ba	March	ove	, jus
	Sta Registr		31. Data filed (Month, Day, Year) MAR 1 7 1000	-	Registrar's Signa	4	book	1					

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State of Maryland / Department of Health and Mental Hygiene

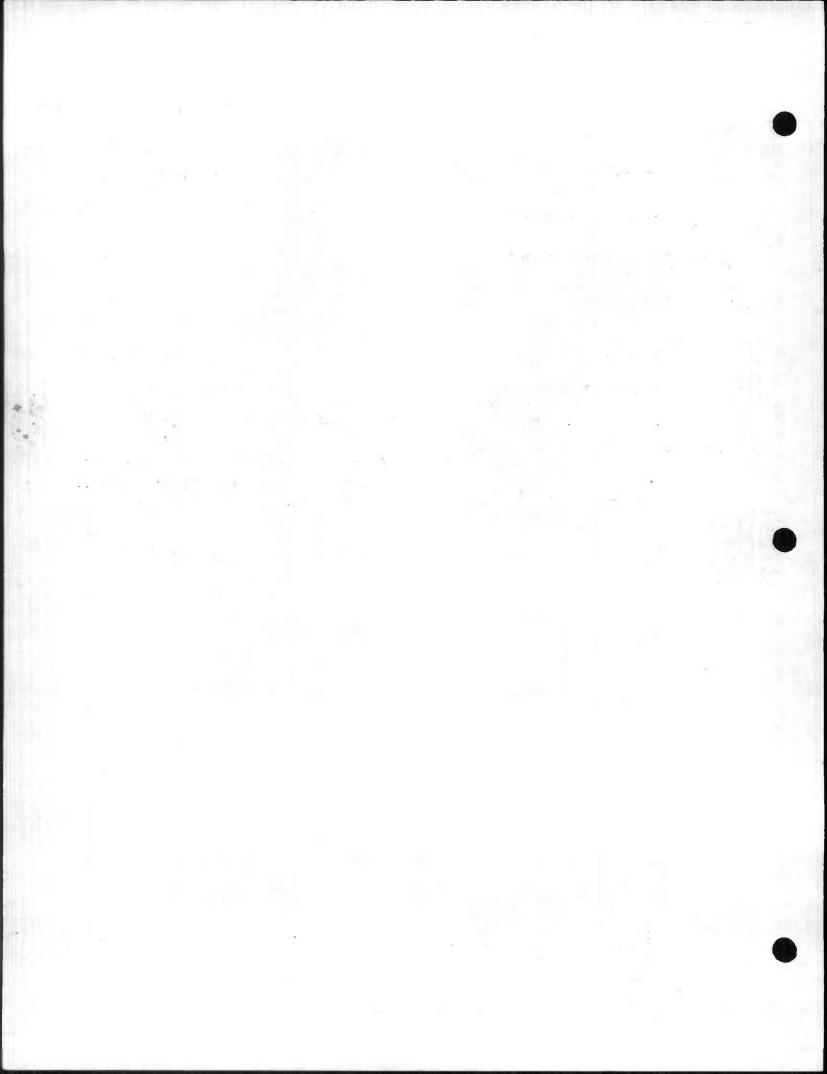
oparament or r	ioditii diid	IVICITO
Certificate of	Death	

2 2			Cei	tificate o	f Death	R	eg. No. 9	UB	211
Physician	Decedent's Name (First, Middle, La.	st) Ga	ry Conr	ad B	ennett	2. Date of Deal Month March 1	th Day	Year	3. Time of Death 10:00
/Medical Examiner	4a Facility Name (If not institution, giv	re street and number)			4b. City, Town, or I		4c. County		10:00
LAMITINE	8001 CHARLESMONT	ROAD			DUNDALK		BALT	IMORE	
Funeral Director	5. Social Security Number 6. S		(In yrs. last birthday) 65 Yrs.	If Under 1 Yes Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, July 28	Year)		ce (State or Foreign
and **	10a. State 10b. County		10c. City, Town or Lo	cation				100	d. Inside City Limits
death with the Maryland rms 23a or 28a-f show rmst be notified at neral Director	Maryland Bal	timore			Dundalk				1 ☐ Yes 2 No
with the Mar or 28s-f a be notified Director	10e. Street and Number			10f. Zip Code			Og. Citizen of		
ath v	8001 Charlesmont				21222		United		
5 28 5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ⊠ Yes 2 □ N If Yes, Give Year or Dates: 1	0	Nas Decedent of I Yes, specify Co	t Hispanic Origin? (Suban, Mexican, Puert o Specify:	pecify Yes of No- o Rican, etc.)		ck, White, et White, white, wh	te.
d 2 should be filed within 72 hours aft th and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Event To Be Completed by F	15. Decedent's E. (Specify only highest gra Elementary/Secondery (0-12)	ducation	16a. Deced	lent's Usual Occ kind of work dor DO NOT use reti	supation ne during most of wor ired)	king	16b. Kind of B	usiness/Indu	stry
filed within Hygiene. Ther then then then then then then then then	12 Years	1 Year	Che	ef	T				ration
should be filed nd Mental Hygi merked other umetic event, T To Be Cc	17. Father's Name (First, Middle, Last)					ne (First, Middle, I			
should be nd Mental marked o umatic ev	Matthias Conrad				-	phine		lot Kno	
od 2 should be filed within th and Mental Hygiene. It is marked other than traumatic event, the M	19a. Informent's Neme/Relationship (Mr. Michael A. E	,, , , , , , , , , , , , , , , , , , , ,			et and Number or Ru ridge Dri				
# Health Heen 27 other tr	20a. Method of Disposition	Jenneec .	20b. Place of Dispo	sition (Name of	1		20c. Location		
Pages nent of h unt: If the kry or of	1 ⊠ Burial 2 ☐ Cremation 3 ☐			natory or other p					
	4 Donation 5 Other (Specif		Holy Rosa	. Name and Add		7/1999	Dundal	.K, Ma.	Lyland
parmit Depart Import any inj ance	How &	200		ouda-Ruc	k Funeral se Ave. D				c 222
Physician /Medical Examiner	23a Part 1. Enter the Osease, or companded, or heart stature. Latterly Immediate Cause (Final disease or condition resulting in death)	. Andeno	SUSTOTIC Due to (or as a consec	CASIO					Approximate nterval Between Onset and Death
v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit leted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence to (or as a consequence)						
ath certificate be exattending physician for use as the burial clan/Medical E		d						1	
death of for u	Part II. Other eignificant conditions o	ontributing to death but	t not moulting in the u	Morhina cause	oiven in Part I	23h Did to	phaceo una co	ontribute to 1	the cause of death
es that the death ce igned by the attend be detached for us by Physician/		on the state of th	THE TOTAL PROPERTY OF THE TOTAL PROPERTY OF	loonying datase	given are are i.		ee 2□ No		ably XX Unknow
S 25 G						24a. Was a periori	med?	com	e eutopsy findings lable prior to pletion of cause eath?
The page						MY	es 2 No	18	Yes 2 No
or Attending Physician: The street death. Director: After this certificate in by the funeral director, pagertification: To Be Coertification: To Be Co	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only on	10)		
Physician: r this certific and director,	1™ Yes 2□ No	Hospitat: 1 ☐ Inpatier		3LI DOA		lome 5 Reside	ence 8 🗆 Oth	ner (Specify)	
ath. c: After t ne funera	27. Manner of Death 1 Stieturat 5 Pending 2 Accident Investigation	28a. Date of Injun (Month, Day	Year) 28b. Time of Injury	28c. In W	jury at /ork? □ Yes 2 □ No	28d. Describe h	ow injury occur	rred	
tal or Attanding P rs after death. el Director: After led in by the funer Certification:	3 Suicide 6 Could not be determined	289. Place of Inju	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)						
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	ysician: To the best of niner: On the basis of and manner stat	examination and/or im	occurred at the restigation, in m	time, date and place y opinion, death occu	, and due to the corred et the time, d	ause(s) and make,	anner as sta and due to t	ted. the cause(s)
To the within To the comp	29b. Signature and title of certifier	Amille	ull		c.M.E.		9d. Date signe MARCH		
101	30. Name and address of person who Margarita Korell.		ath (Item 23a) (Type,		altimore.	Maryland	21201		-11/20

State Registrar

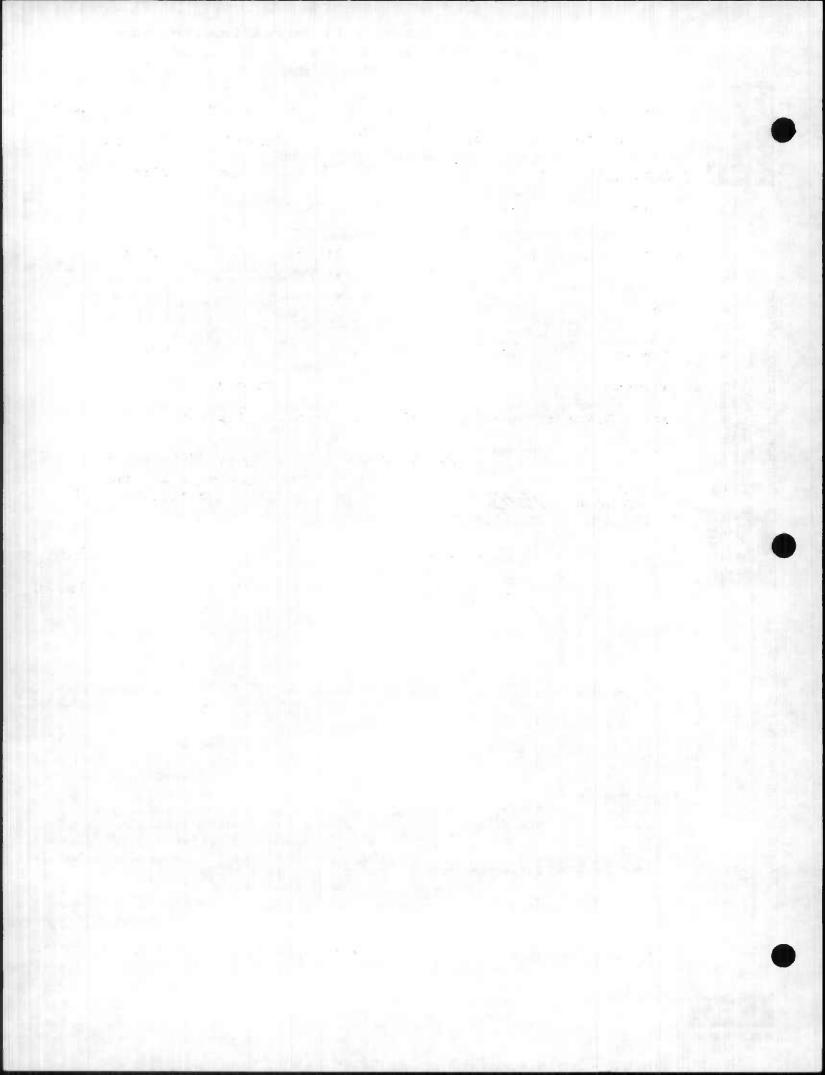
31. Date filed (Month, Day, Year) MAR 17 1999

Sporks



			Certific	cate of Death	R	leg. No.	00210				
	1. Decedent's Name (First, Middle, La.	st)	V-7 KID94		2. Dete of Dee Month		3. Time of Deeth				
Physician /Medical	George	A.		Burrell	MARCH	12 199					
Examiner	4e Fecility Neme (# not institution, give	e street end number)			or Location of Death	4c. County of	of Deeth				
	THE JOHNS HOPK	INS HOSPITAL			TIMORE		N/A				
uneral irector	5. Social Security Number 229-03-6706 Usual Residence of Decedent	ex 7. Age (In yr 1 M 2□ F 8 2		nder 1 Year If Under 24 I oths Deys Hours A	Hrs. 8. Date of Birth Min. (Month, Dey Mar 18	Year) 1916	Birthplece (State or Foreign Country) VA				
f show	10a. Stete MD 10b. County	N/A 10c. 0	City, Town or Location	BALTO			10d. Inside City Limits				
el', or tems 23s or 28s-f show Employer must be notified at by Funeral Director	10e. Street and Number		10	f. Zip Code	1	0g. Citizen of W					
aral sral	2716 E. Chase		116 40 110 5	21213	2 (Cassity Van as No	U.S.	A •				
leted by Fund	11. Maritei Stetus 1 Never Married 2 Merried **TWidowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes ZZNo If Yes, Give Year or Detes:		specify Cuben, Mexicen, Posses 2 X No Specify:	r (Specify Yes of No- uerto Rican, etc.)	Bleck	K, White, etc. BLACK				
Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16e. Decedent's (Give kind of life. DO No	Usuel Occupation If work done during most of Tuse retired)	working	16b. Kind of But	ainess/Industry				
Somp	Elementery/Secondery (0-12) unknown	College (1-4or 5+) N/A	unkno			N/A					
Be	17. Fether's Neme (First, Middle, Last)				Name (First, Middle,	Malden Sumeme	9)				
2	unknown 19a. Informent's Neme/Reletionship (Tuna Print)	10h Mailing Ade	dress (Street end Number o	nknown	r City or Town	State Zin Codel				
	Janice Baker/S	TEPdaughter	2716 E	Chase st	Balto,	Md 21	213				
Department of Important: If it any Injury or one once.	20e. Method of Disposition 1 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Removal from State	Plece of Disposition cemetery, cremetory	corother place)	3-18-99	Balto					
	21. Signature of Furneral Service Licensee 22. Name end Address of Facility Betts Funeral HOm 1129 N. Caroline St Balto, Md2										
	23e. Pert1. Enter the diseese, or com shock, or heert feilure. List only	plicetions that caused the de	eth. Do not enter the	mode of dying, such as car	diec or respiretory en	rest,	Approximete Intervel Between				
ian cal ner	immediate Ceuse (Finel disease or condition resulting in death)	· Preum	2019				12 days Years				
ةِ 🍱		1	(or es e consequence	9 01):			Yeurs				
Examiner	Sequentially list conditions,		(or es e consequence	of):			, cars				
<u>e</u>	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury	C									
Medical Examir	that initieted events resulting in death) Lest	Due to	(or es e consequence	of):							
d for use	Pert II. Other significent conditions o	ontributing to death but not re-	eculting in the underly	ing cause given in Bert I	23h Didt	phaceo use con	tribute to the cause of death'				
by Physician/M	Total Surginion Condition	Sittibuting to death but not in	estiming in the underly	ing couse given in Fett.	i)X		3 Probably 4 Unknow				
should					24e. Wes e perfor		24b. Were eutopsy findings aveilable prior to completion of ceuse of death?				
Comple 2					1□ Y	es 2 No	1 ☐ Yes 2 ☐ No				
Be C	25. Was cese referred to medice! examiner?			26. Plece of	Death (Check only or	ne)					
E 0	1 Yes 2 No	Hospital: Impatient 2	☐ ER/Outpatient 3[□ DOA Other: 4 □ Nursir	ng Home 5 Resid	ence 6 □Othe	or (Specify)				
	27. Manner of Deeth Naturel 5 Pending Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe h	ow injury occurre	ed				
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At building, etc. (Spe	home, farm, street, facily)	ctory, office	28f. Location (S City or Tow	cation (Street and Number or Rurel Route Number, y or Town, State)					
completely filled in by Medical Certifi	29a. Certifier To Certifying Ph (Check only one) 2 Medical Exam	yaician: To the best of my kininar: On the basis of examinend menner steted.	nowledge, death occunetion end/or investig	rred et the time, date end p atlon, in my opinion, death o	lece, end due to the o occurred et the time, o	euse(s) end mei date end place, e	nner es steted. and due to the cause(s)				
Me	29b. Signeture end title of certifier			29c. License number	1	29d. Dete signed	I (Month, Day, Year)				
	Mil Ber	h_llit	tom 22a) (Time State)	RESOUC) /	March	12,1999				
	30. Name and eddress of person who	completed ceuse of death (it		026 St B	Batto, MD 2	1000-					
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Sig			a Ho MD	1 403					
	28 m t C 0 8 s	00 No	12	1 1/1							

Hegistra



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Data of Death 3 Time of Death Day **Physician** Month March 13, 4:45 am 1999 Joshua Peter Backe /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Baltimore City Sinai Hospital If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Sacurity Number If Undar 1 Year 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Days 1□XM 2□ F Yrs March 13, 1999 Maryland Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☒ No Directo Maryland Baltimore Pikesville 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 407 Greenwood Road U.S.A. Funeral 21208 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status 1 X Navar Married 2 ☐ Marriad 1 ☐ Yas 2 No Specify: Specify: Black Completed by 3 ☐ Widowad 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada complated) Elementery/Secondary (0-12) College (1-4or 5+) never employed 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) Be Peter Backe Michelle Ford 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 407 Greenwood Road, Pikesville, Maryland 21208 Peter Backe (father) 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from State MAR. 16 4 ☐ Donation 5 ☐ Other (Specify) St.Charles Borromeo Cemetery Pikesville, Maryland 22. Nama and Addrass of Facility
Loring Byers Funeral Directors, Inc. 21. Signature of Funaral/Sarvice Licansii 8728 Liberty Rd. Randallstown, Maryland 21133 1400804 23a Part . Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such es cerdiac or respiratory errest, bock, or heert feilure. List only one ceuse on each line. Approximata Intarval Batwean Onsat and Death Immadiata Causa (Final disease or condition rasulting in daath) Multiple fetal anomalies - Trisomy 18 Due to (or es e consequance of): Examiner Sequentially list conditions, if eny, laading to immediate causa. Entar Underlying Cousa (Diseasa or Injury thet initiated avants rasulting In daath) Last Dua to (or es e consequance of): Physician/Medicai Due to (or es a consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to complation of cause of deeth? 24a. Was an autopsy performed? Be Completed 1 ☐ Yas 2 No 1 ☐ Yes 2 No 25. Was cese refarred to madicel 26. Pleca of Death (Check only ona) Hospital: 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 5 Panding invastigation 1 Naturel Injury 1 ☐ Yas 2 No 2 Accidant N/A N/A 6 Could not be datarmined 3 Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Cartifiar 💢 Cartifying Physician: To tha bast of my knowledga, daath occurred at tha tima, data and place, end dua to tha ceuse(s) end mannar as steted. (Check only one) 2 Madical Exeminer: On tha basis of axamination and/or investigation, in my opinion, daath occurred et the time, date end plece, end dua to tha ceusa(s) and mannar statad. 29b. Signatura, and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) 000 23440 30. Nama and address of person who complated ceusa of daath (Itam 23a) (Type, Print) Guy Jackson, MD Sinai Hospital of Baltimore 2401 W. Belvedere Ave

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 7 1999

32. Registrer's Signeture

Funeral

Director

"natural", or itams 23a or 28a-f ahov edical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter of Department of Heelth and Mental Hygiene. Important: If Nem 27 Ia marked other then "natural", or iten any injury or other treumatic event, the Medical Examiner.

Physician

/Medical

Examiner

physician and s the buriel-trensit

been signed by the should be detached

has 19 2 s certificate has director, page 2

Hospital or Attending Physician: 24 hours after death.
Funerel Director: After this certificately filled in by the funeral director, p.

To the Hospital or within 24 hours aft To the Funerel Di completely filled in

The law requires that the death certificate be executed

Box 68760.

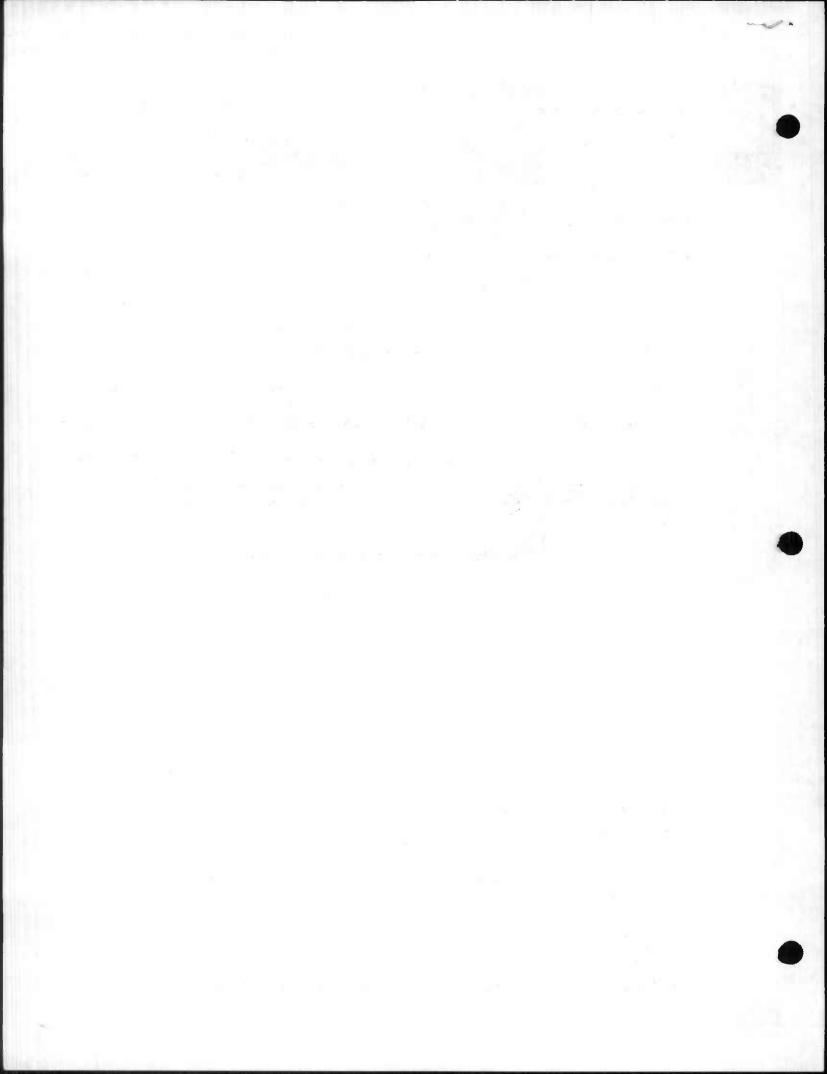
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Records,

Division of Vital

Baltimore, Maryland 21215-0020

death with the Meryland



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** Hervey Groff Brackbill 1999 8:45 PM March 6 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner Baltimore 2620 Poplar Road Woodlawn 8. Dete of Birth (Month, Dey, Year) If Under 1 5. Social Security Number Year If Under 24 Hrs. Birthplece (State or Foreign Country) Sex 1X M 2□ F 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min 98 Yrs. 213-03-2544 March 2, 1901 Pennsylvania Director Usuel Residence of Decedent the Meryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location r 28a-f show ehow. 1 ☐ Yes 2 No Maryland Baltimore Woodlawn Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 and 2 should be illed within 72 hours after death with ent of Health and Mentel Hygiene.

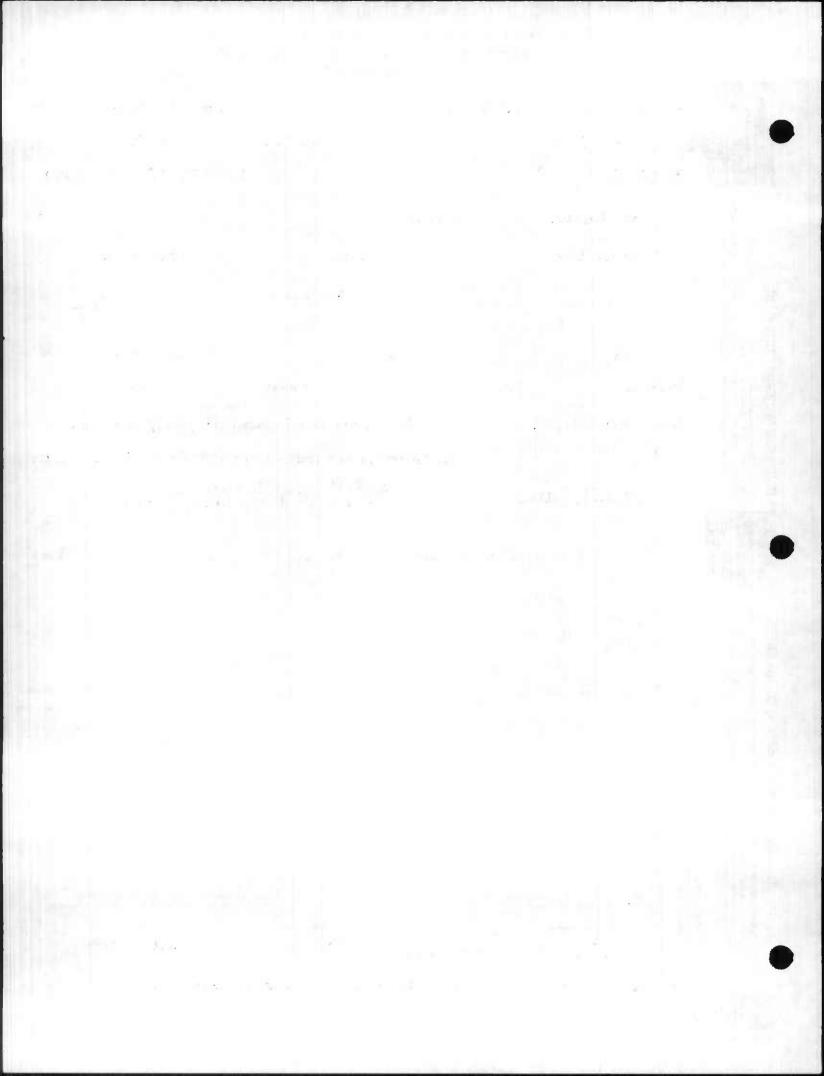
nt: if item 27 is marked other than "natural", or items 23s or
iry or other traumatic event, the Medical Exeminational be a 2620 Poplar Road 21207 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Editor Newspaper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) William Brackbill Amanda Groff 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Mel Bowers / Nephew 2560 Forest Knoll Annapolis, Maryland 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 1 XBunel 2 □ Cremetion 3 □ Removel from Stete permit. Page Depertment of Important: If I any injury or once. St. Stephen's Church Cemetery 3/18/99 Crownsville, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Servica Licansee Mitchell-Wiedefeld Home, Inc. Steven T. Bottle 6500 York Road Baltimore, Maryland 21212 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Finel diseese or condition resulting In deeth) Consestie Heart Faclour /Medical Huer Examiner Due to (or es e consequence of): Examine physicien and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): ettending p e deteched 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Whknown þ sign 1 be 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed is certificate has director, page 2 1 Yes 2 TNo 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: 1 Maturel 5 Pending 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner es stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) end menner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of cartifier ecaleo March 8, 1999 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Michael B. Pearlman, M.D. 5400 Old Court Road Randallstown, MD 21133 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

B. Sports



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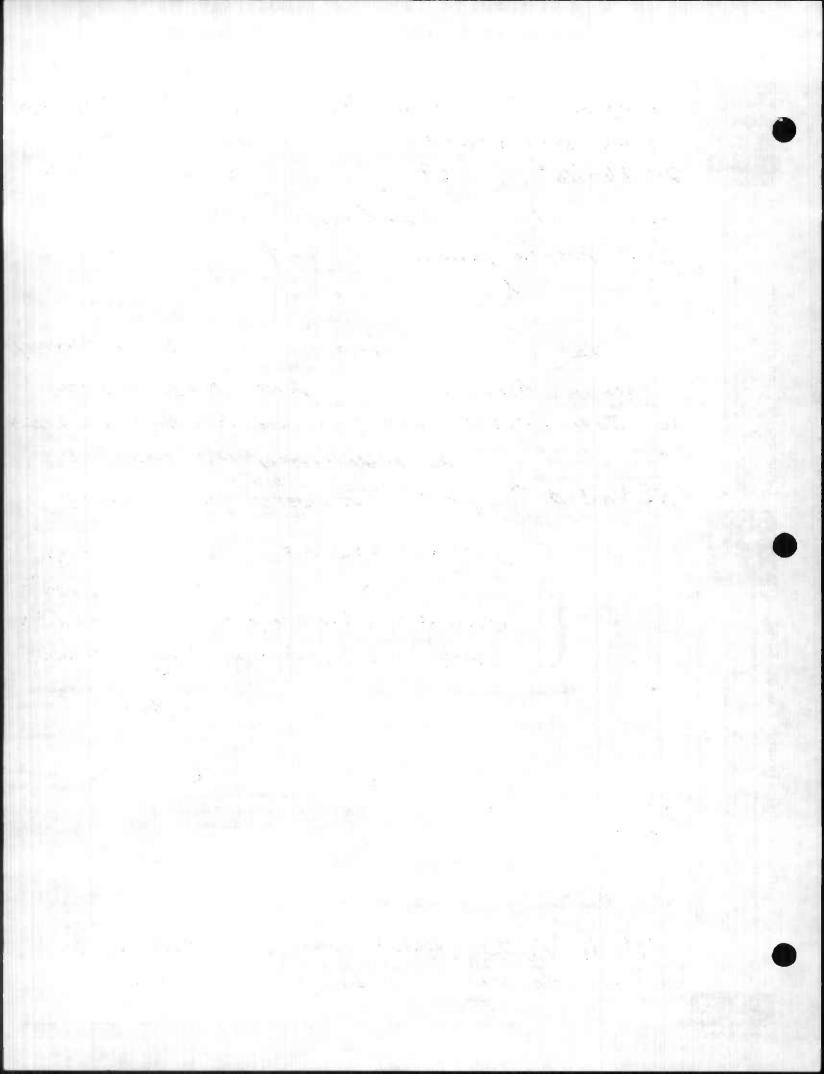
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) **Physician** Bielski 4:25 pm asimir March /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, giva street and number) 4c. County of Death Examiner Hopkins Bayview BALTIMORE If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) if Undar 1 Yaar 6. Sax 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplace (Stata or Foraign Country) 2/826457811€M 2□ F Usuel Rasidance of Dacedant Days 7 Yrs. **Director** death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits ir than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yas 2 No ALTIMORE Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 2511 USA AVENUE Funeral 12. Was Decedant Evar In U.S. Amay Forcas? 1 [7 as 2 □ No If Yas, Giva Yaar or Datas:] 0 18 - 5 2 Was Decedant of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race · American Indien. Black, White, atc. 1 Nevar Married 2 Married 1□ Yas 2□No Baltimore, Maryland 21215-0020 Spacify: þ WHITE 3 Widowed 4 Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Il Hygiena. Elamantary/Secondary (0-12) Collaga (1-4or 5+) SOCIAL SECURIT ELECTRICIAN 12 other 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Is marked of CASIMIR BIELSKI BIELAMOWICZ 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other treum once. AUG BALTO, MD 2122; JOHN 627 S. LAKEWOOD 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Burial 2 Crametion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Addrass of Facility

KACZORO SILI 21. Signatura of Funaral Sarvice Licensas 23a. Part1. Entar tha disaesa, or compilications that ceused tha death. Do not antar the mode of dying, such as cardiac or raspiretory arrast, shock, or heart failure. List only one cause on each line. 2525 FLEET ST. Approximata Intarval Batween Onsat and Daeth **Physician** immediete Cause (Finel disaasa or condition rasulting in daath) /Medical pneymonia Examiner Examiner raplegia requires that the death certificate be executed attending physician and for use as the burial-trans Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaase or injury that initiated avants rasulting in daath) Last Spinal cord Injury Physician/Medicai laminectomy 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? Yas 2 No 25. Was cesa rafarrad to madical examinar? Be 26. Placa of Daath (Chack only ona) 1 Yes 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) P 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred After t Certification: al or Attending P is after death. It Director: After 5 Panding 1 TYes 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida To the Hospital o within 24 hours af To the Funeral Di edical 29a. Cartifian Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian RES-000 Resident 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) North Wolfe Street Baltimore 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

MAR 17



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** JOAN ANN BAILEY 1999 4:30 AM MARCH 16 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORG HOSPITAL BALTIMORE SAMARITAN 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sax **Funeral** 10 M 2 KF 218-28-4814 67 March 10.1932 Maryland Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at 1 Yes 2 No Maryland Baltimore Directo Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4327 Falls Park Rd. 21128 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U.S. 11. Maritel Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. should be filed within 72 hours efter ond Mentel Hygiene.
marked other than "natural", or Her 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White. by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home 10th Grade Homemaker permit. Peges 1 and 2 should be file Department of Health and Mentel Hy, Important: if Itam 27 is marked othe any injury or other traumatic event, page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilbur James Kavanaugh Romaine Trimmer 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Donald Bailey 4327 Falls Park Rd.. Perry Hall, MD 21128 (son) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Parkwood Cemetery 3/19/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236 21. Signeture of Funeral Service Licensee Marks T. Zavoyon 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical MYOCARDIAL INFARCTION Examiner Due to (or as e consequence of): Examiner RENAL DISEASE STAGE end Il-fransit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence of): physician er s the burial-f Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): attending pl signed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? been si 24a. Wes an autopsy performed? Completed certificate has b 1 ☐ Yes 2 No 1 Yes 2 No director, or Attanding Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident ofter deeth Director: / d in by the f 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homiclde To the Hospital or within 24 hours eft To the Funeral Di completely filled in 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number P12563 MARCH 16 1999 Clelia NEGELNI, n.D.

5601 LOCH RAVEN BOULEVARD

BALTIMORE M.D

Registrar

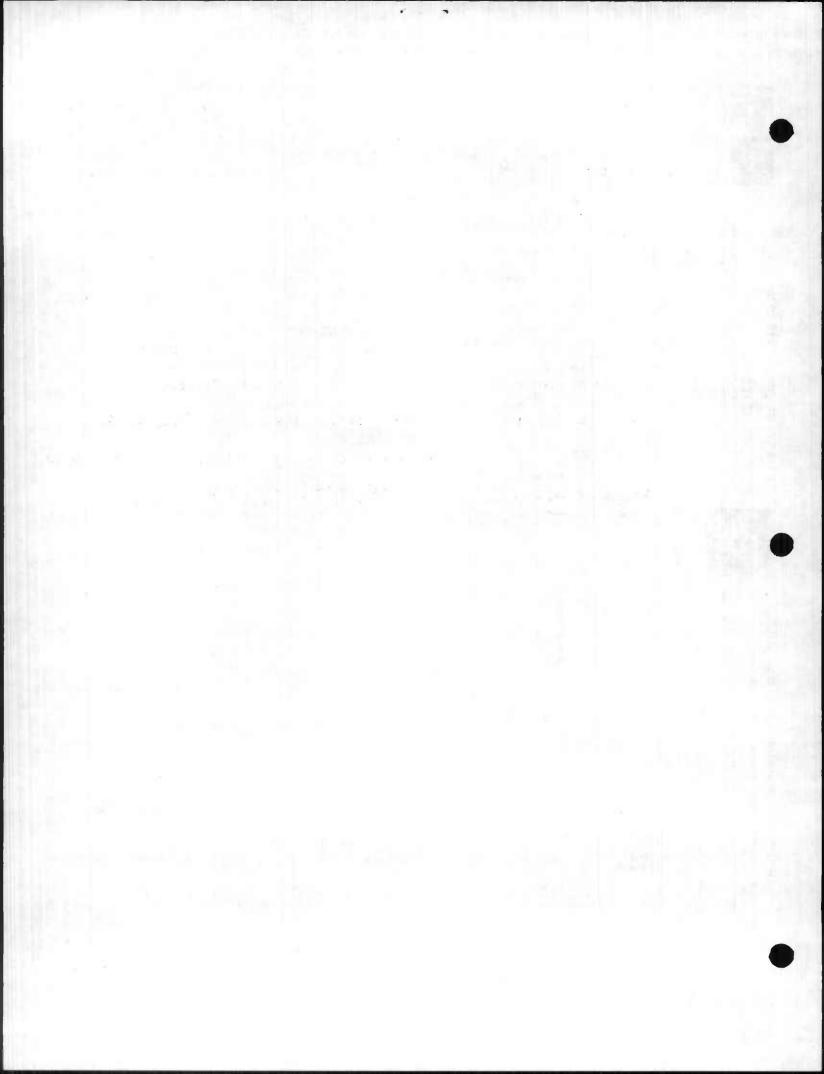
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1999

NEGLINI, ND. GOOD SAMARITAN HOSPITAL

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Beech Scothe 30 A MARCH 1999 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE CITY if Under 24 Hrs. 6. Sex 1 X M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 54 Yrs. 289-38-2608 Nov. 9,1944 Alabama Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 9024 Perryvale Road 21236 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Hospital Administrator 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John Beech Ila Howell. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9024 Perryvale Road, Baltimore, MD Mrs. Jane E. Beech (wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State Green Mount Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 3/15/99 Baltimore, Maryland 22. Name end Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funerel Service Licensee Buran a Willen 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Cerebral Immediate Cause (Final OHE WEEK disease or condition resulting in death) 9 ac stream Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Ischance cardiony opulle Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 45 Unknown anticoaquilation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes PV No 1 ☐ Yes 2 No 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospitel: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 1 Salaturel

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or flama 23a or 28a-f ahow the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death 1 Department of Heelth and Mental Hyglene. Important: If Nem 27 is marked other than "natural". ~ Managing avenue.

Funeral Director

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Completed

Be

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Box 68760,

P.O.

Records,

Division of Vital

Hospital

To the Hosp within 24 hou To the Fune completely fi

Examiner The lew requires that the deeth certificate be executed Physician/Medical Completed by or Attending Physician: Be Medical Certification: To this After n 24 hours after death.

Funeral Director: Aftivities yield in by the fun

1 Yes 2 No

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation

MAR 17

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

111)

32. Registrer's Signeture

28b. Time of Injury

28c. tnjury et Work? 1 □ Yes 2 □ No 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Bultmore

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. License number

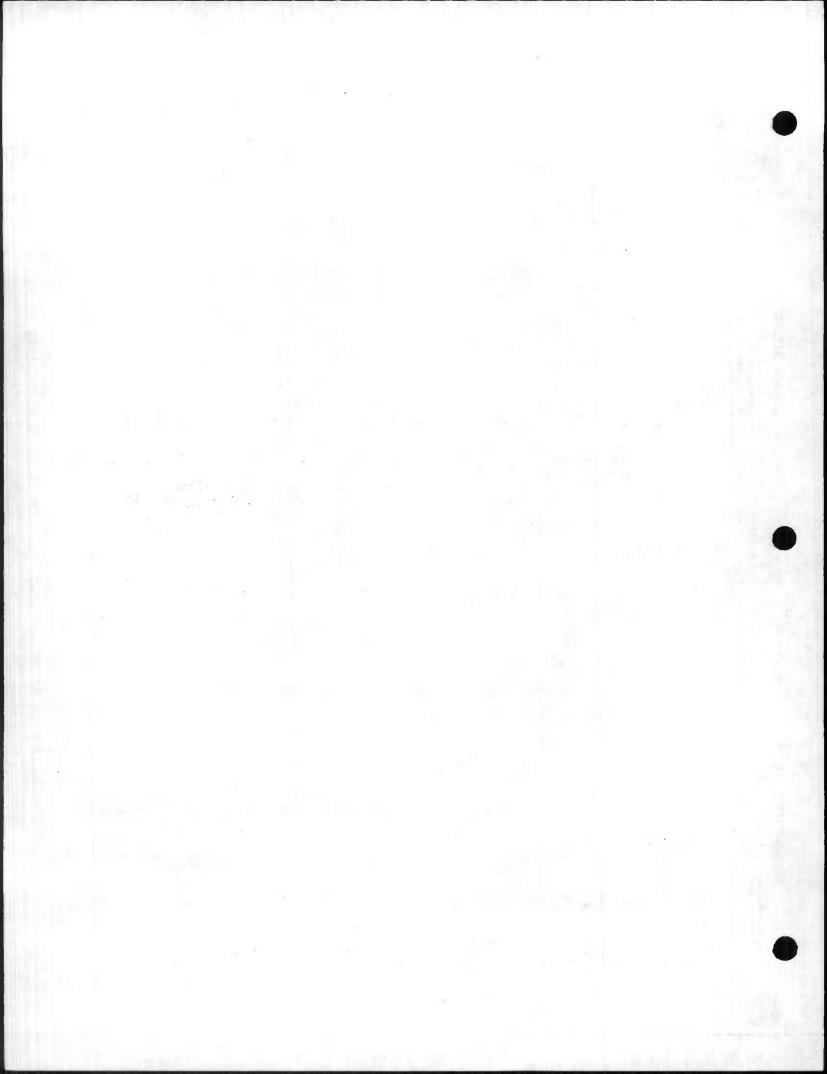
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who completed cause of deeth (Item 23a) (Type, Print) 600 orth 0 9

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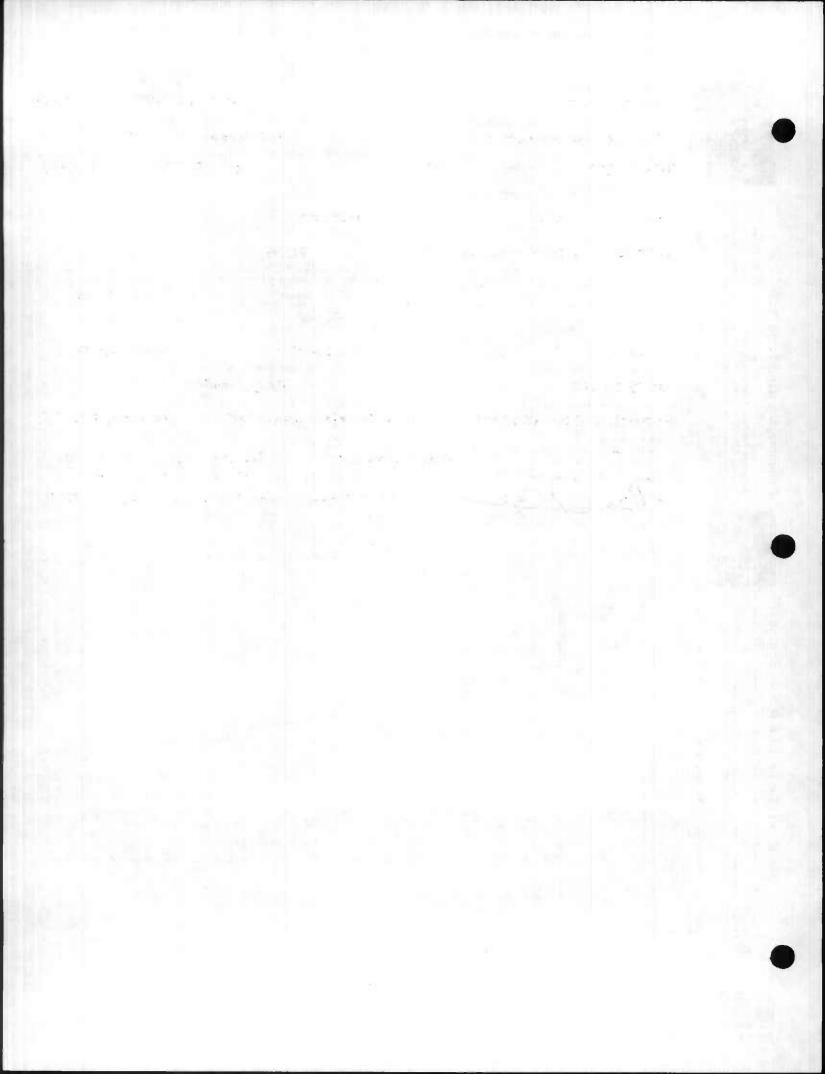
State Registrar



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State of Maryland / Department of Health and Mental Hygiene 9 08281

				Certifica	ite of	Death		R	eg. No.	0 (
Physician /Medical	1. Decedent's Name (First, Midd Ingrid Curry							2. Deta of Deef March]		9 ^{Year}	3. Time of Death 2:07pm	
Examiner	4a Facility Nama (If not Institution Bayview Medical Section 1988)						alti	more		of Deeth		
Funeral Director	5. Social Security Number 204-38-2802	6. Sex 1□ M 2 X F	7. Age (In yrs. last bii 49	Yrs. If Und Months	er 1 Yaer s Days	If Under 24 Hours	4 Hrs. Min.	8. Data of Birth	^Y 21949	9. Birthp	lece (Stete or Foreign	
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21215-0 ad within 72 ho rgiene. we than "neturn t, the Medical I	15. Decede (Specify only high Elementery/Secondary (0-12)	nt's Education est grede completed)		Decedent's Us (Give kind of v life. DO NOT	vork done use retire	during most o d)		g	16b. Kind of Bu		13.	
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To the within 2 To the compla	29b. Signature and title of certif	ntoop SI	of olinear	an la	29c. Licens	sa number		2	29d. Data signe	d (Month,	Day, Year)	
3	30. Name and address of perso	who completed caus	e of delath (Item 23e)	(Type, Print)	EAN	enr e	Ive	BALT	muse Ma	12	224	
State Registrar	31. Date tiled (Month, Dey, Yea MAR 1		egistrer's Signeture	B. 2	psea	las !	,	7.7	, ,,,,,			



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ANTWAN CHASE

State of Maryland / Department of Health and Mental Hygiene

O Date	of Dooth		2	Time
f Death	Reg. No.	U) (0
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Physician
/Medical
Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 271s marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Modical Economic must be notified at any Injury or other traumatic event, the Modical Economic must be notified at any Injury or other traumatic event, the Modical Economic must be notified at any Injury or other fraumatic event, the Modical Economic must be notified at any Injury or other fraumatic event, the Modical Economic must be notified at a second and the first beautiful to the Modical Economic must be not the Modical Economic must be

Baltimore, Maryland 21215-0020

/Medical Examiner the attending physician and hed for usa as the bunal-transit

Physician

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, signed by the a cata has been signated; After this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funaral director,

			Cer	unca	ie oi	Deam	_		Reg. No.		1
Decedent's Nama (First, Middla,	Last)							2. Data of Dea Month	Day	Year	3. Time of Death
ANTAWN D. C						45 Ob. To	um arta	MARCH		99	11:19P.M
4a Facility Name (If not institution,		m <i>ber)</i>						ocation of Death	4c. County		
ST.AGNES HOSPITA				If I loads	ar 1 Yaar		TIMO			N/A	
5. Social Security Number 217 90 0382 Usual Residence of Dacedant	. Sex 1∰ M 2□ F	7. Aga (In yrs. 21	Yrs.	Months			Min.	8. Data of Birtl (Month, Day 10/29/	7. Year)	9. Birti	nplace (State or Foral untry) MD.
10a. State 10b. County		10c. Ci	ity, Town or Lo	cation			-				10d. Inside City Limi
MD. N/A			BALTIM	IORE							1 ∰ Yes 2 □ N
10e. Street and Number			DALIT		ip Code		_		10g. Citizen of	What Co	untry?
2549 McHENRY	CTDEET			102		2					
	STREET	edent Ever in U	10 10 1	Mac Dao	2122		lain? (Sne	acify Vac or No.	US 14 Bac		rican Indian,
11. Marital Status 1 ∰ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F	orces? 2∰No ve		f Yes, sp	- 11			ecify Yas or No- Ricen, etc.)	Bla	ck, White	
15. Decedent's			16a. Dece	dent's Us	ual Occu	pation			16b. Kind of B	usinass/i	ndustry
(Specify only highast Elamantary/Secondary (0-12)	completed) College (1-4or 5+)	life.	DO NOT	use ratire	during mos	it of work	ing			
12	0	. 30. 01,	none	9					none		
17. Fathar's Name (First, Middla, La	st)					18. Mothe	er's Name	e (First, Middla,	Maiden Sumar	ne)	
KEITH C	HASE						JAC	QUELINE	WHEATL	EY	
19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	ss (Stree	t and Numb		al Route Numbe			'ip Code)
JACQUELINE WHEA	TLEY		254	19 Mc	HENF	RY ST.	BAL	TO. MD.	21223		
20a. Mathod of Disposition		20b.	Place of Dispo	sition (Na	ame of	2001		Date	20c. Location	- City or	Fown, State
#☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	ESTERN				3	/15/99	CATON	ISVII	LE, MD.
21. Signature of Funaral Servica Lice						ess of Facili		7 207 30	0,,,,		,
23a. Part1. Enter the disease, or or shock, or heart failura. List or	emplications that ly ona causa on	ausad tha daa each line.	ith. Do not ent					LTO. MD or respiratory ar		.7	Approximata Interval Between Onset and Death
Immediate Cause (Final disaase or condition resulting in death)	a. Mul	Due to (gunsh of as a consec	o + quence of	Weu	inds	of	head	d	1	
	■ b										
Sequentially list conditions, if any, laading to immediate		Due to (or as a consec	quence of	f):						
Causa, Enter Underlying Cause (Disaasa or Injury	C.									i	
that Initiated evants resulting In daath) Last		Dua to (or as a consec	uence of):						
	- d									i	
	<u> </u>										
Part II. Other significant conditions	contributing to d	eath but not ra	sulting In the u	nderlying	causa g	iven In Part	l.	23b. Dld 1	obacco uae co	ontribute	to the cause of dear
								10	Yes 2 No	3 🗆 Pr	robably 4 Unknown
		~			Ħ			24a. Was perfo	an autopsy mad?	8	Were autopsy finding
								120	res 2□No		completion of causa of daath?
25 Was once referred to medical						00 51					- M - CO - EU 140
25. Was cese referred to medical examiner?	Hospital:		Denote :		0	thar		h (Check only o			-:4-1
1% Yes 2 No 27. Manner of Death	28a. Data		ER/Outpatier		JUA	4 L N	ursing Ho	ome 5 Rasid			ory)
1 Natural 5 Panding	(Mor	th, Day Year)	Injury	М	28c. Inju	ork? Yas 2	ľNo				
2 Accident Investigat 3 Suicida 6 Could no	ha J	9-99	untrae	wn			,,40	Subjec 1	t wa	5 S	chet ural Route Number, Catherine
4 Homicida detarmin	250. Place	of Injury - At hing, atc. (Speci	ify)	eet, facto	ory, office	,					
			walk								arxland
29a. Certifier 1 Certifying (Check only 2X Medical Ex	Phyaician: To the barniner: On the b	best of my knows of example	owledga, daatl	h occurre	d at the t	ime, date ar	nd place,	and dua to tha	cause(s) and m	anner as	stated.
one)	and mar	nar stated.	and district in			se number			29d. Date sign		
29b Signature and title of certifier				12	PRICE L ICENT	ise number			COU. LISTE SIGN	DU HYTOHIO	71. LACKY. 1 CONT. 1

29a. Certifier (Check only one)

Stephen S.
31. Data filed (Month, Day, Year)

O.C.M.E.

29c. Licanse number 29d. Date signed (Month, Day, Year)

MARCH 10, 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Typa, Print)

Radent

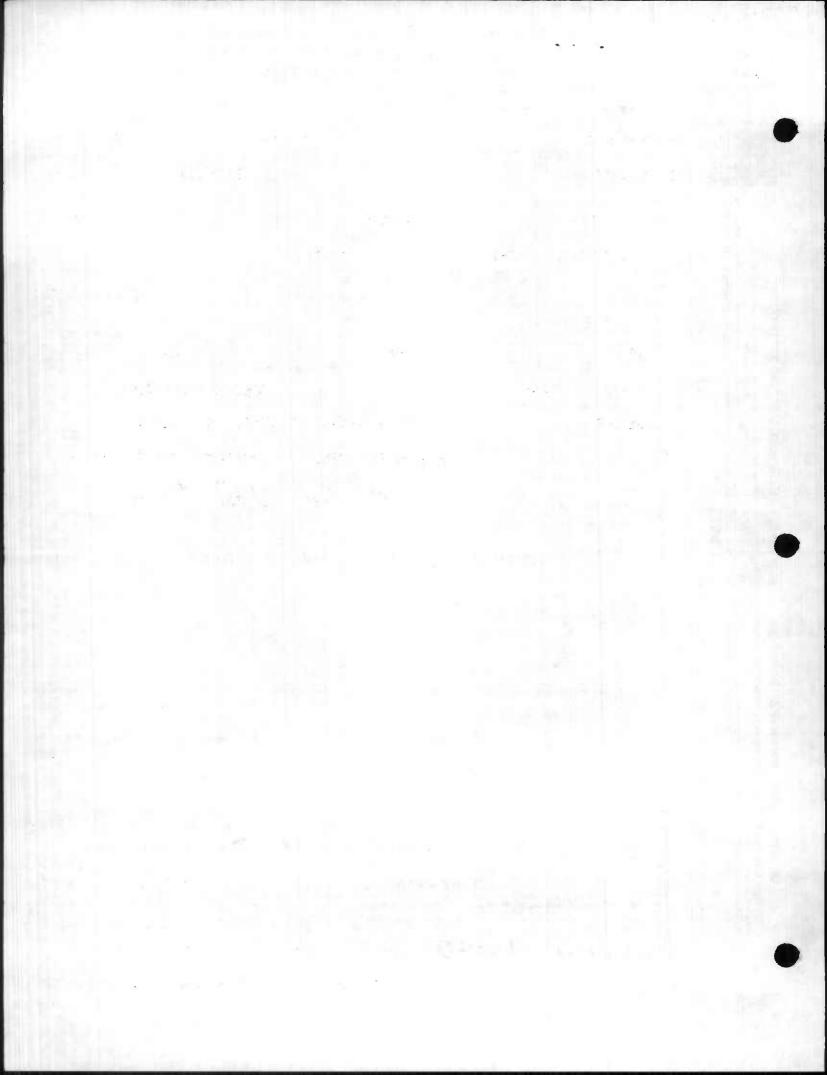
2

111 Penn Street, Baltimore, Maryland 21201

State Registrar

MAR 1 7 1999

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Deeth 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** 10:48 PM MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner MORE 259 N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) Birthplece (Stete or Foreign Country) **Funeral** Months Days Hours Min. 1X M 2□ F Yrs. 554-74-4562 56 Bangkok, Thailand **Director** Sept. 24, 1942 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland N/A Baltimore 10f. Zip Code 10e. Street end Number 10a. Citizen of Whet Country? 5536 Bucknell Road United States of America 21206 Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes: 1 Never Married 2 X Married 1 Yes 2 XNo Specify: Specify: Asian by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 04 12 Computer Operator Garment Industry 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Balwant K. Bhalla Sunder S. Chona 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) Mrs. Baljit K.(nee Sodhi)Chona (Wife) 5536 Bucknell Road Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burlal 2 X Cremetion 3 ☐ Removel from Stete 3/18/1999 Towson, Maryland Hillton Service Corporation 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. "Jeffrey L. Gair 1050 York Rd. Towson, Maryland 21204 his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximata Intervel Between Onset end Death **Physician** ACIDOSIS Immediate Cause (Final diseese or condition resulting in deeth) лиесіса Examiner NEARCTION Physician/Medical Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SEUDOMONAS 24b. Wera eutopsy tindings eveilable prior to 24a. Wes en eutopsy Completed completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No 25. Was case rafarred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpetient 3 DOA 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Dey Year) Certification: 27 Menner of Deeth 28c. Injury et Work? Naturel 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida The rtifying Physician: To the best of my knowledga, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as statad. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the tima, dete end place, end due to the ceuse(s) and mannar statad. 29e. Certifie edicai

deeth certificate be executed P.O. Box 68760. Division of Vital Records,

with the Maryland

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Heelth end Mental Hygiena. Important: If item 27 ia marked other than "natural", or itema 234 any injury or other traumatic event, the Medical Examiner.

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paga 2 has

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After

eftar 24 hours efter Funeral Dire detally filled in b

within 2

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completaly

altimore,

Attending 6 To the

> State Registrar

29b. Signature and title of certifier

(Check only one)

29c. License number

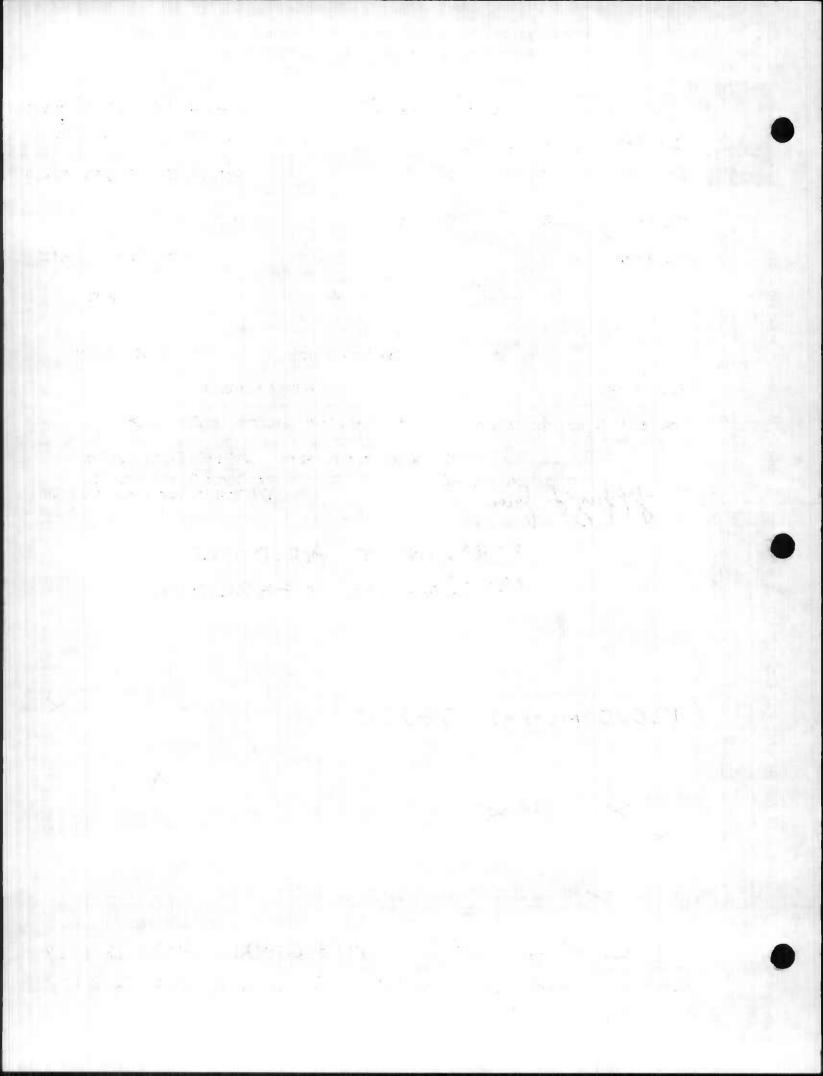
29d. Date signed (Month, Day, Year)

30. Neme end address of person who completed cause of death (Itam 23a) (Type, Print) SINGER

HOSPINA SINM

32. Registrer's Signature

31. Dete tiled (Month, Day, Year) 7 MAR 1



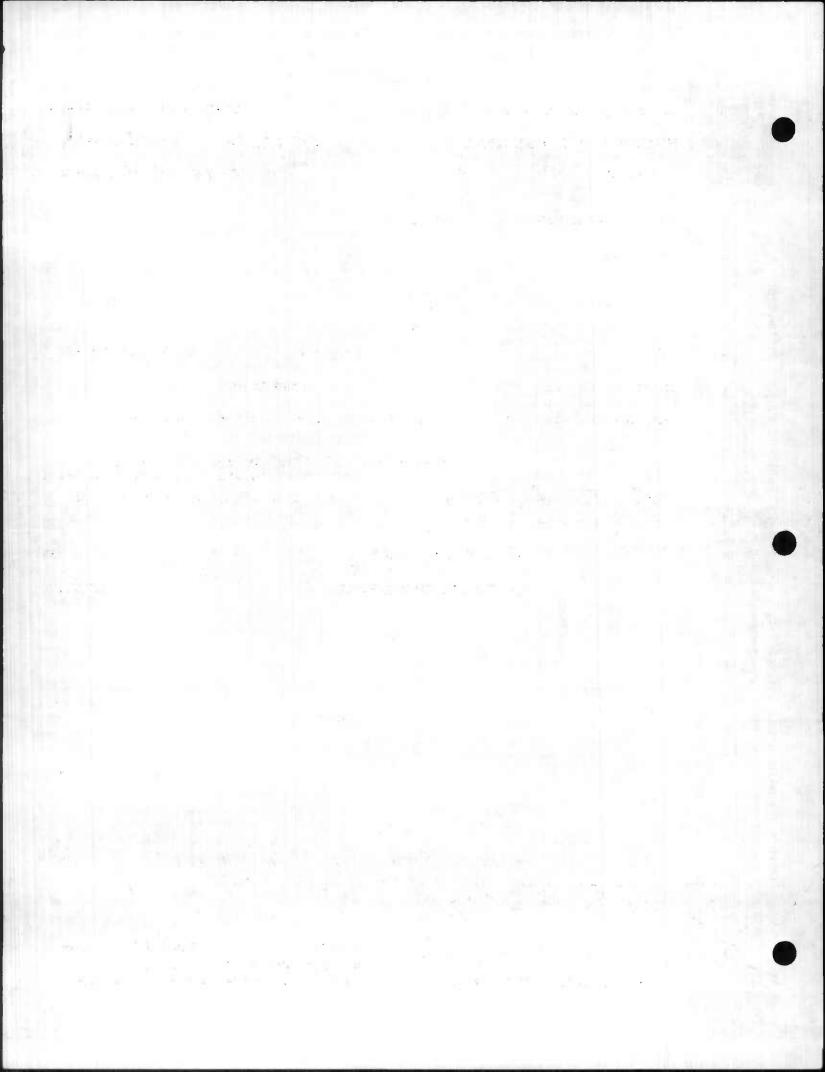
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Physicia /Medic	an al	Edward	Erskin Co	rnick	her)			4b. Cit	v. Town, or L	Month FEBRUA		Year 1999 nty of Death	6:50 P.M	
Examin	er		Married 2 Married 2			A -	ORGE'S							
Funeral Director		5. Social Security 577-46-	y Number 6. S	ex 7	7. Age (In yrs.			ear If U	nder 24 Hrs.	8. Date of B		9. Birth	place (State or Foreigntry) ington, D	
	-	Usual Residence			10c C	ty Town or Lo	ocation						10d. inside City Limit	
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7 is marked other than "natural", or thems 29s or 28s-f show traumstic event, the Medical Examiner must be notified at	by Fur		arried 2 Married	Armed For	ces? 2 NRet:	ired				pecify Yes or N o Rican, etc.)	14. F B Spen	lece - Amer lack, White cify: B1		
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17. Father's N Edwar 19a, Informat														
T T	-					19b. Malli	ng Address (St	reet and A	lumber or Ru	ral Route Num	ber, City or Tov	vn, State, Z	ip Code)	
Lawrence Co		ce Cornick	, son					e, Sta	afford,	VA 225	54			
ar oth				Removal from S		Place of Dispo cemetery, crei	osition (Name o matory or other	f place)		Date	20c. Locatio	n - City or 1	Town, Stete	
		4 Donation	4 Donation 5 Other (Specify) Mullins & Thompson Crematory 3/3/99 Stafford, VA											
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State Registrar

31. Date filed (Month, Day, Year) MAR 1 7 1999

MITCHELL V.MATHIS, LCDR, USN, MC 32. Registrar's Signeture

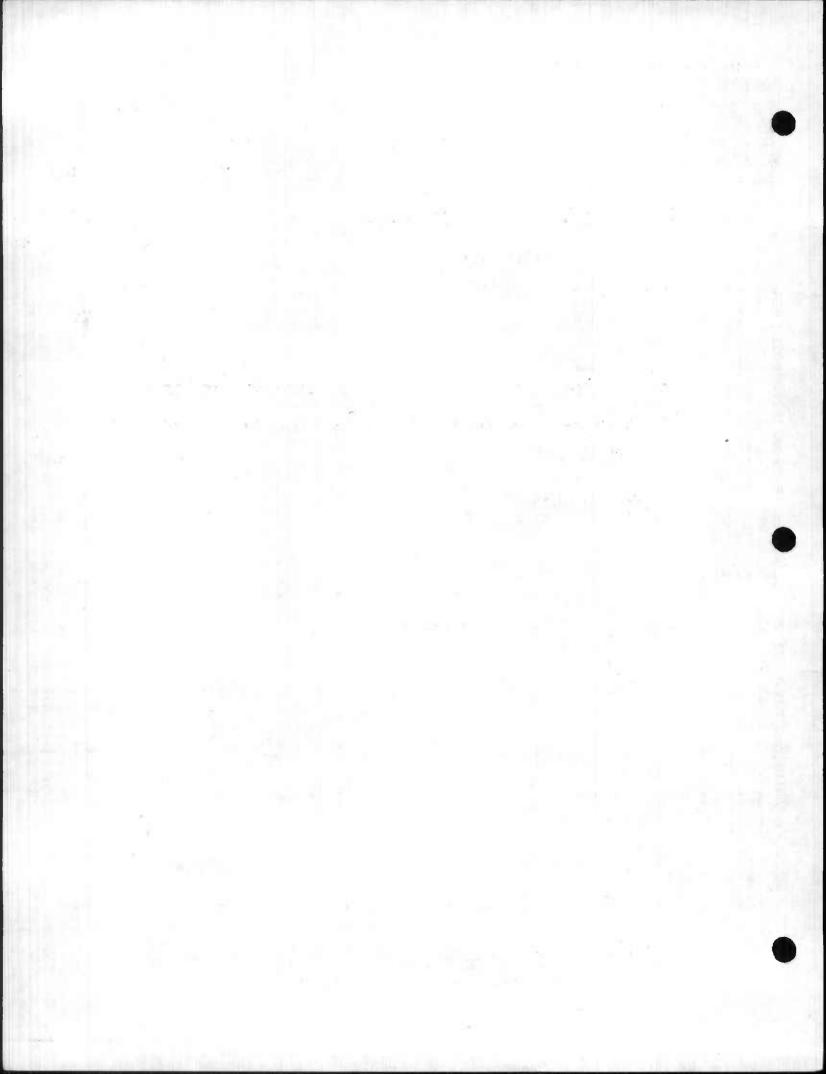
ANDREWS AIR FORCE BASE, MD 20762-6600



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State of Maryland / Department of Health and Mental Hygiene

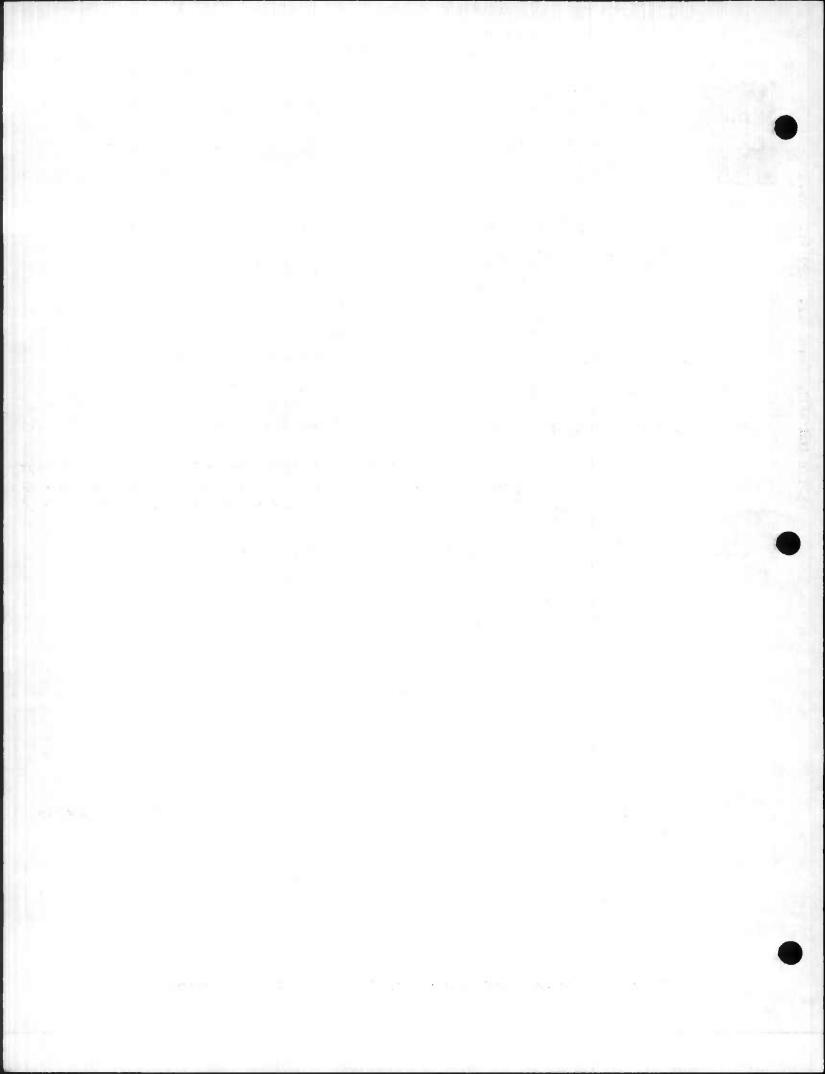
Item 3	O Per DVR FilmG76	9 3-17-9	9 rja	Certific	ate of Dea	th	F	leg. No.	UO	200			
	Decedent's Name (First		^				2. Date of Dea Month		Year	3. Time of Death			
Physiciar /Medica		MALEI	< CHEATHA	M			MARCH	7	1999	17:44			
Examine	4a English Nama /Mast is	nstitution, give s	treet and number)		4b. City	, Town, or Lo	cation of Death	4c. County	of Death				
	UNIVERSITY OF	MARYLA	ND MEDICAL S	MSTEMS	B	ALTIM	ORE						
Funeral Director	5. Social Security Number 220-53-69	6. Sex				nder 24 Hrs. urs Min.	8. Dete of Birth (Month, Day	Year) C Q	9. Birthpla Country	ce (Stete or Foreign			
with the Maryland a or 2844 show De notified at	Usual Residence of Dece 10a. State 10b.	County	10c. C	ity, Town or Location					100	d. Inside City Limits			
Mar I	e Ma	NIA		haltimor	16					1₽Yes 2□No			
vith the Ma	10e. Street and Number	A . /			Zip Code			0g. Citizen of \	Vhat Country	y?			
Man of the state o	1965 1	Cally	natur the					119	A				
deeth ma 23	11. Marital Status	COLL	2. Was Decedent Ever in U	J,S. 13. Was De	cedent of Hispanic	Origin? (Spe	city Yes or No-		e - Americar				
15-0020 72 hours effer deeth with the Maryle fractural; or ferms 23s or 28s-1 should be notified at	1 Never Married 2		Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1120	pecify Cuban, Men 2 No Spen		Hican, etc.)	Specify	k, White, et	o.K			
72 hours	15. 0	ecedent's Educ		16a. Decedent's U	sual Occupation			16b. Kind of B	usiness/Indu	stry			
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ond 2 selfth are tree.	Ne no A	nolma.	Come doutles	10151	Callina	1- 1 A	= An1	Lana	141.				
Health em 27	20a. Method of Dispositio	ICH ELM?	200.	Place of Disposition (Vame of	TONIT	Date Date	20c. Location	City or Tow	n, Stete			
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Baitimore, N pemil. Pages 1 end Department of Health important: if them 27 eny Injury or gither tr pages.	21. Signature of Funeral	Milo	Λ.		and Address of F	3011	at Mi	Broad	losay	1 rome			
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Examiner	resulting in death)	8		or as a consequence	of):				1	5 days			
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death car death car e attandin od for usa													
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require sense					1	15	24a. Wes a	n autopsy med?	evail	e eutopsy findings lable prior to pletion of cause sath?			
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or, par		medical			00.0	Nana of Dooth		- 1*		103 20 110			
Of Vital Rec Physicien: The iew ribis certificate hes b vral director, page 2 s			ospitel: 1 1 Inpatient 2	3ED/Outration of	Other		(Check only o		ne /C==='4 ·				
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DIVISION C tal or Attending P is a thar death. I Director: After i led in by the funera Carriffication:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injury - At I building, etc. (Speci	M 1 ☐ Yes 2 ☐ No Be. Place of Injury - At homa, ferm, street, fectory, office building, efc. (Specify)					281. Location (Street end Number or Rurel Route Number, City or Town, State)				
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of the of the one of the one		certifier	/		29c. License numl	ber		29d. Dete signe	d (Month, D	ay, Year)			
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				State of Marylar			t of Health and e of Death		giene	08	289	
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	/Medic Examin		4e. Fecility Neme (If not institution, give				4b. City, Town,	or Location of Death	4c. County	of Deeth	1,000	_
	Examin		STELLA MA	ARIS HOS	PIC	E	BALT	MORE		1/10		
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.		day) If Under	1 Year If Under 24 H	rs. 8. Dete of Bir	th (9. Birthple	ece (Stete or Foreigny)	gn
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	show	_	10e. Stete 10b. County		_	or Location				10	d. Inside City Limits	
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	efter dec or Items	Š	11. Marital Status	12. Wes Decedent Ever In U Armed Forces?	,S.	If Yes, spec	ent of Hispenic Origin? ify Cuben, Mexican, Pu	(Specify Yes or No erto Ricen, etc.)	Hec Bled	e - America ck, White, e		
2	rs efter	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:		1□ Yes 2	No Specify:		Specify	12,	hav	
វី	72 hours efter dee "natural", or Items contai Examine m		15. Decedent's Ed		16e. D	ecedent's Usua	I Occupation		16b. Kind of Bu	usiness/Ind	ustry	_
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			23a. Pert1. Enter the diseese, or companies shock, or heert failure. List only	plications that caused the deet	h. Do no	t enter the mode	of dving, such es cerd	liac or respiretory e	rrest.	ORE, M	Approximete	
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	ate be executed nysician and he bunal-transit	Examiner	Sequentially list conditions	b	,	nsequence of):						
5	an ar		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
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2	physic this ce al dire	10	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outp	etient 3 DO	A Other: 4 □ Nursing	Home 5□ Resi	dence 6XIOth	er (Specify	HOSPICE	
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2	endil eath. or: A the fu	ati	2 ☐ Accident investigation			М	1 ☐ Yes 2 ☐ No					
>	r Att	Certific	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm	n, street, fectory	, office	28f. Location (City or To	Street end Numb wn, Stete)	er or Rurel	Route Number,	
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	the the I	Med	one)	end manner steted.								
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							043725		311	2190)	
	V		30. Neme end eddress of person who									
	8		DR. TARIQ MAHMO 31. Dete filed (Month, Dey, Year)			VALLEY 1	RD. TIMONI	UM, MD 2	1093			
	Sta Registra	- 1	MAR 1 7 19	32. Registrer's Signe	lure /	9. ho	sechel					
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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. Item 10d Per FH FilmG770 4-19-99 rja State of Maryland / Department of Health and Mental Hygiene Item 17 Per FH Film G769 3-17-99 rja Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** March 12, 1999 GUY EDWARD COOK 2:26 AM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Baltimore County If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** 1QM 2□ F Months 219-07-2566 79 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f ahow 1 ☐ Yes XXX No Directo Maryland Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herna 23a 2805 Second Avenue 21234 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 Tyes 2 □ No If Yes, Give Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Serv. Rep. BGE Company 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) permit. Peges 1 and 2 should be file.
Department of Heelth and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic aventone. Be Guy Edward Cook, Sr. Marie Kurtz.

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Interment's Neme/Relationship (Type, Print) 11863 Sherbourne Drive, Timonium, MD Linda Carol Bauer (Daughter) 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Parkwood Cemetery 3/15/99 Parkville, Maryland 21. Signature et Funeral Service Licensee 22. Name and Address of Fecility Martin D. Lawson Mitchell-Wiedefeld Home, Inc. Martin D. Lawson

6500 York Road, Baltimore, Maryland
21212

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Intervel Between Onset and Death **Physician** - Possible MyoGnoist INFARCTUS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca ot): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence ot): P.O. Box 68760, Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Bud Stage Neural Bises & on Dizly 65
Hypertensive Cardio vascale Bises 1 Yse 2 No 3 Probably 4 Tonknown Division of Vital Records. Completed by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an eutopsy Agrestensive Nephroscleross -1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? or Attending Physician: 26. Place of Death (Check only ona) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending e Hospital or Attending n 24 hours after deeth. e Funeral Director: After 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, term, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b. 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier from M.O. 017148 3-12-99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4706 Harford Road, Baltimore, Maryland 21214 Donato A. Vargas, Jr.

DHMH 16 Rev 6/95

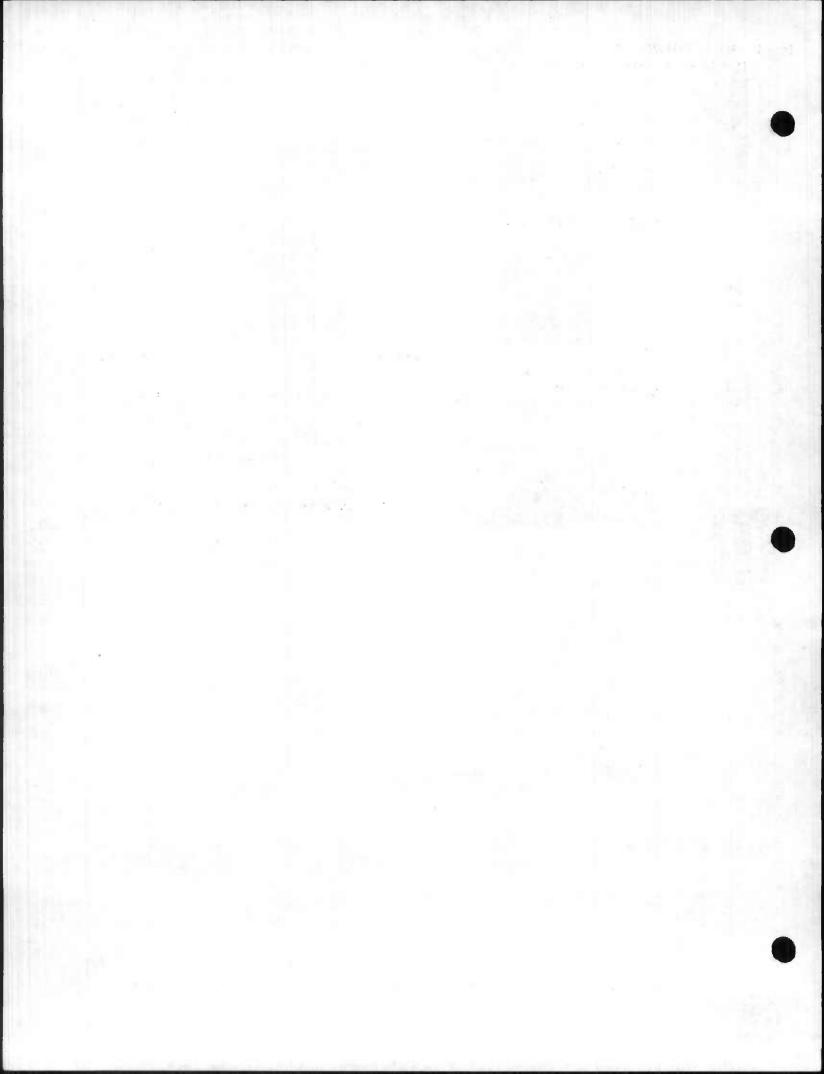
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Registrar

31. Dete filed (Month, Day, Year)

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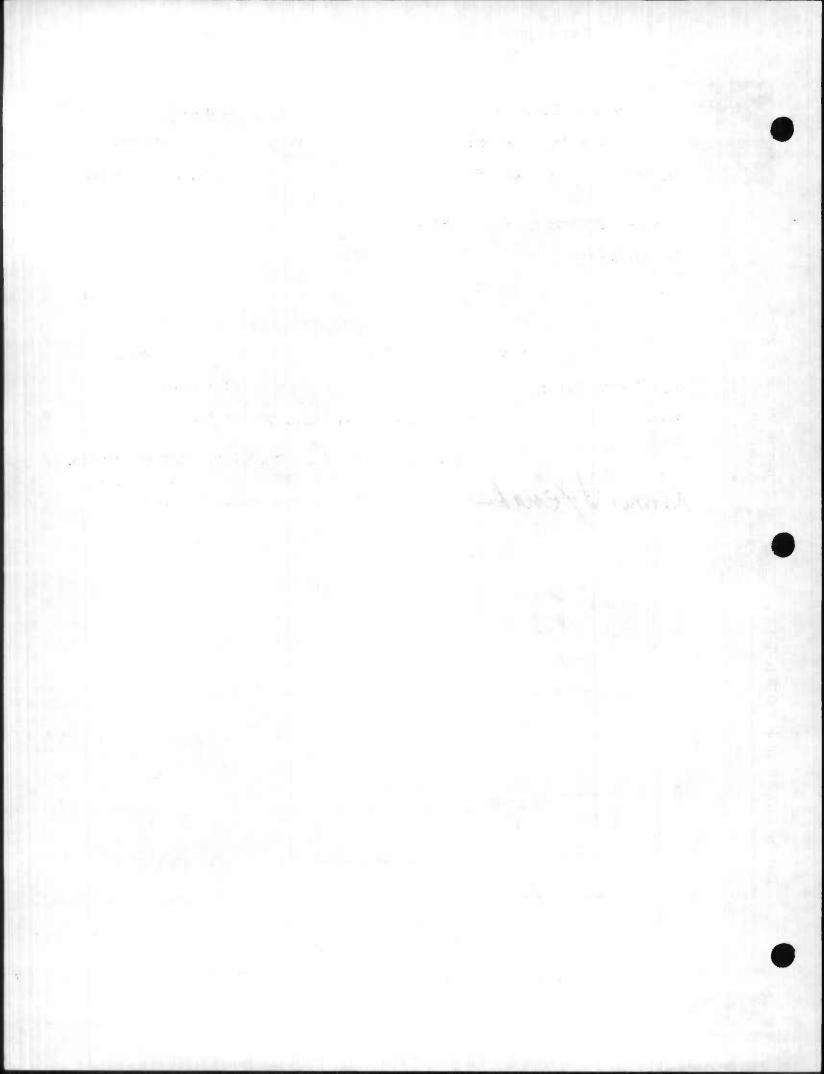
32. Registrer's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Ce	ertifica	te of	Death			Reg. No.		John W	
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	-	Da. State	10b. County		100.	City, Town or I	Location	_			<u> </u>			10d. Inside City Lie	mits
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Completed by												an autopsy omed?	a	Vara autopsy findir vailabla prior to ompletion of cause f daath?	
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Be Com		5. Was case refer	med to medical						26. Placa	of Death (Check only				
. 0		examiner?	No	Hospital:	Inpatiant 2	ER/Outpat	ent 3 🗆 [OOA O	Marie a			dance 6 0	thar (Spec	ify)	
e funeral o	2	7. Manner of Deal 1 Matural 2 Accident	th 5 Pending investigatio	28a. Data (Mon	of Injury oth, Dey Year		of	28c. Inju		28		how injury occu			
completely filled in by the funeral Medical Certification:		3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28a. Placi	of Injury - A ing, atc. (Spe	t home, ferm,	straat, facto	ory, office		28		(Street and Nun wn, Stata)	nber or Rui	al Routa Number,	
edical C	2	9a. Certifier (Check only one)	1 Certifying Pt	miner: On tha b	a best of my leasis of axam	knowledga, da ination and/or	ath occurre Invastigation	d at tha t on, in my	ima, data and opinion, daat	d place, and	d dua to the at tha tima,	ceusa(s) and n data and place	nannar as , and dua	stated. to the causa(s)	
Me Me		9b. Signetura and	titla of certifiar	A	+ten!	ing n	10 2	9c. Licar	370/	6		29d. Date sign	ed (Month	Day, Year) 5, 199°	7
)	3		rass of parson who		sa of death (Itam 23a) (Typ	e, Print)	s S	h, Sc	ite 4	1105	15-1-	Lane	5, 1999	204
State	3	1. Data filed (Mon			Registrar's Si	anatura									
gistrar		MA	R 1 6 199	a S	meren	19.	An	2011	1						



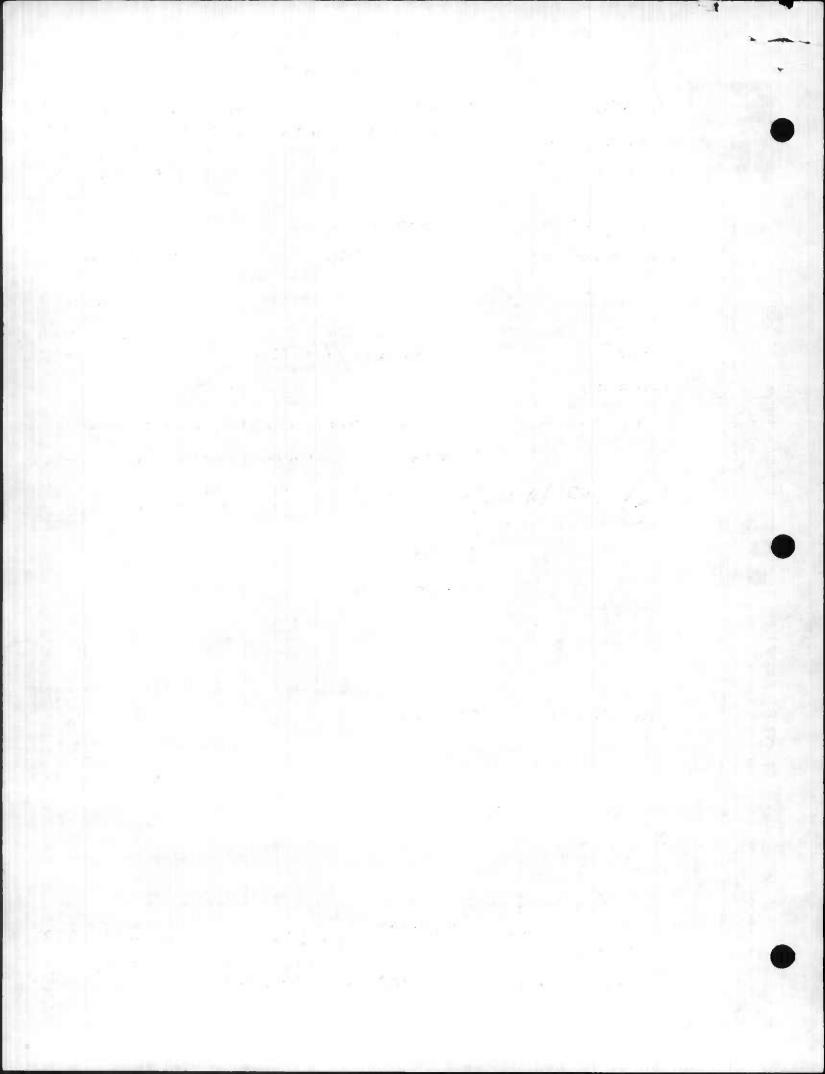
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nema (First, Middla, Last) 2. Data of Death Day Month **Physician** CALP 00:10 AM USTIN 1999 MARCH /Medical 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, giva street and number) 4c. County of Death RANDALLSTOWN Examiner BALTIMORE (ENTER HOSPITAL NORTHWEST Hours | Min. 8. Data of Birth (Month, Dey, Year) If Undar 1 Yaar 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) 6. Sax 1 M 2 □ F 7. Aga (In yrs. last birthday) **Funeral** Months Days Yrs. 219-10-0190 72 Dec. 4, 1926 Director Maryland Usual Rasidence of Decedant The Marylan n 28a-f show 10a Stata 10h. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No Directo Maryland Baltimore Woodstock 10e. Street and Number 10f. Zip Cods 10g. Citizen of What Country? ed other than "natural", or items 23s or event, the Medical Examiner must be a 3008 Hernwood Road 21163 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1∑ Yas 2 □ No If Yas, Giva Yaar or Dalas: 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or law any injury or other traumatic. 1 Navar Marriad 2 Married 1 ☐ Yas 2X No Specify: Specify. þ White 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) LOCAL FALMing Elemantary/Secondary (0-12) College (1-4or 5+) UNION#155 9th Grade lasten FAMMER 18 Mothar's Name (First, Middle, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Marian Calp Florence Philips 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Hazel Calp - Wife 3008 Hernwood Road, Woodstock, Maryland 21163 Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burlat 2X Cramation 3 ☐ Ramoval from Stata Baltimore/Washington Crem. 3/14/99 Laurel, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate
Approximate
Approximate Loring Byers Funeral Directors, Inc. Approximata Intarval Batween Onsat and Death **Physician** Immediata Cause (Final disaasa or condition resulting in death) /Medical CEPS15 Examiner Dua to (or as e consequence of): Examiner AINOMUZN physician and the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or injury that initiated events rasulting In daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequance of): 50 Part it. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? ed by the a 0 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown م PANCREATIC CANCER. Division of Vital Records, by 24b. Wera autopsy findings available prior to 24e. Was an autopsy parformed? Completed peen complation of causa of daath? paga 2 s cartificata has 1 Yas 2 No 1 Yas 2NNo Physician: 25. Was casa rafarrad to medical axeminar? Be 26. Placa of Daath (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) To 1 Yas 2 No this funaral 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how Injury occurred 27. Menner of Death 28b. Tima of Certification: i or Attending F after death. Director: After Aftar 5 Pending invastigation 1 Neturel 2 Accidant 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 3 Sulcida n 24 hours aftar de le Funeral Directo bletaly filled in by the 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 ☐ Homleids Hospital tix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) 29a. Cartifian edicai completaly (Check only one) within 2 and mannar stated. PHYSICIAN 29b. Signatura and title of certifi 29d. Data signed (Month, Day, Year) 29c. Licansa number HOUSE D 42723 1999. MARCH STREAM FOXFORD 3745 29 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) 21236 . BALTIMORE. HARISH VERAHALLI m 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signetura State MAR 17

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Registrar

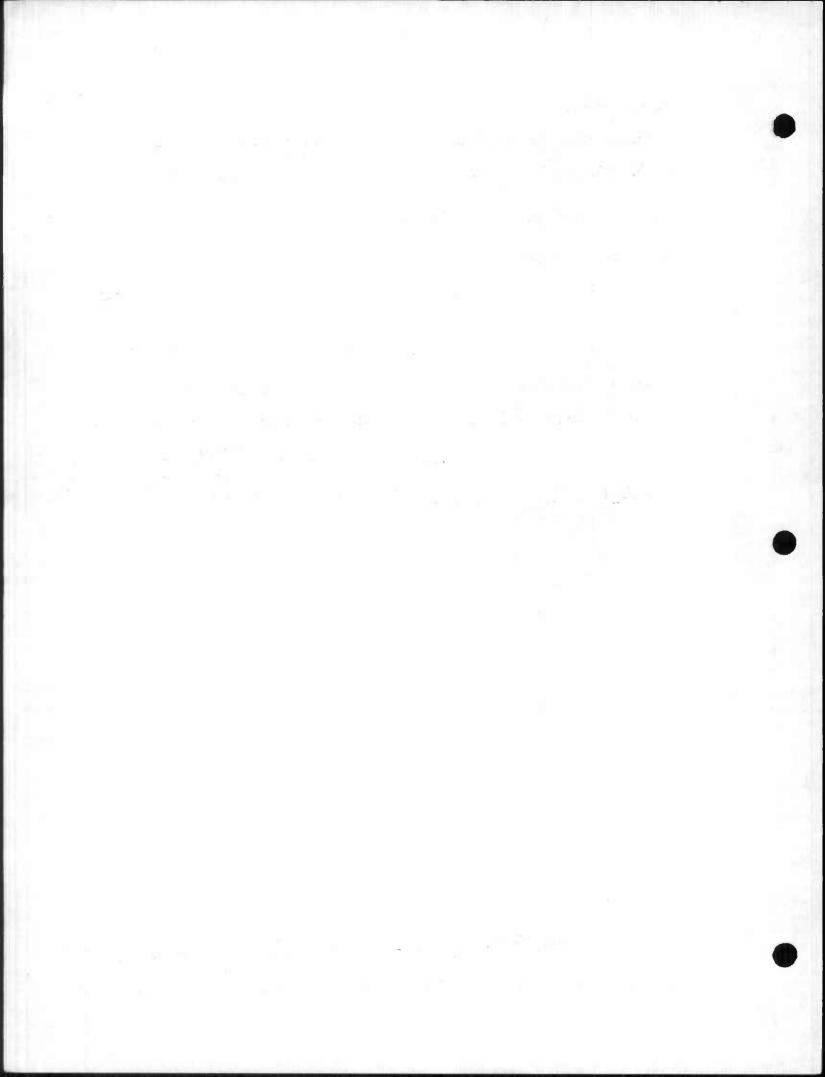


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 1:10PM Carter Christian 1999 March /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Villa Nursing Home Catonsville Baltimore 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F 212-05-3581 Yrs Director May 3, 1914 MD Usual Residence of Decedent deeth with the Meryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Merylan Department of Health and Mental Hygiene. Important: If then 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner may be notified as MD Baltimore 1 ☐ Yes 2 ☐ No Director Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 308 Thackery Avenue 21228 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give WWII Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 Ñ Merried Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 Ho Specify: by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Sales Rep Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) George W. Christian Lillian May Bailey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) Rebecca H. Christian (Wife) 308 Thackery Avenue, Catonsville, MD 21228 20b. Plece of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Baltimore Washington Crem 3/17/99 Laurel, Maryland 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signeture of Funerel Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disease, or complication, that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner signed by the attending physician and d be deteched for use as the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca ol): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? Alzheimeis 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings evalleble prior to completion of cause of death? Completed 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 28. Pleca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28a. Dete of Injury #Manth, Day Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Aocident 3 Sulcide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, Ierm, street, fectory, office building, etc. (Specify) 4 Homicide 1 artifying Phyalcian: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29e. Certifier Medicai 29c. License number 29b. Signature and title of certifie 29d. Dete signed (Month, Day, Year) 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Rechestour Mb 21186 MD 25 grow 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture Registrar

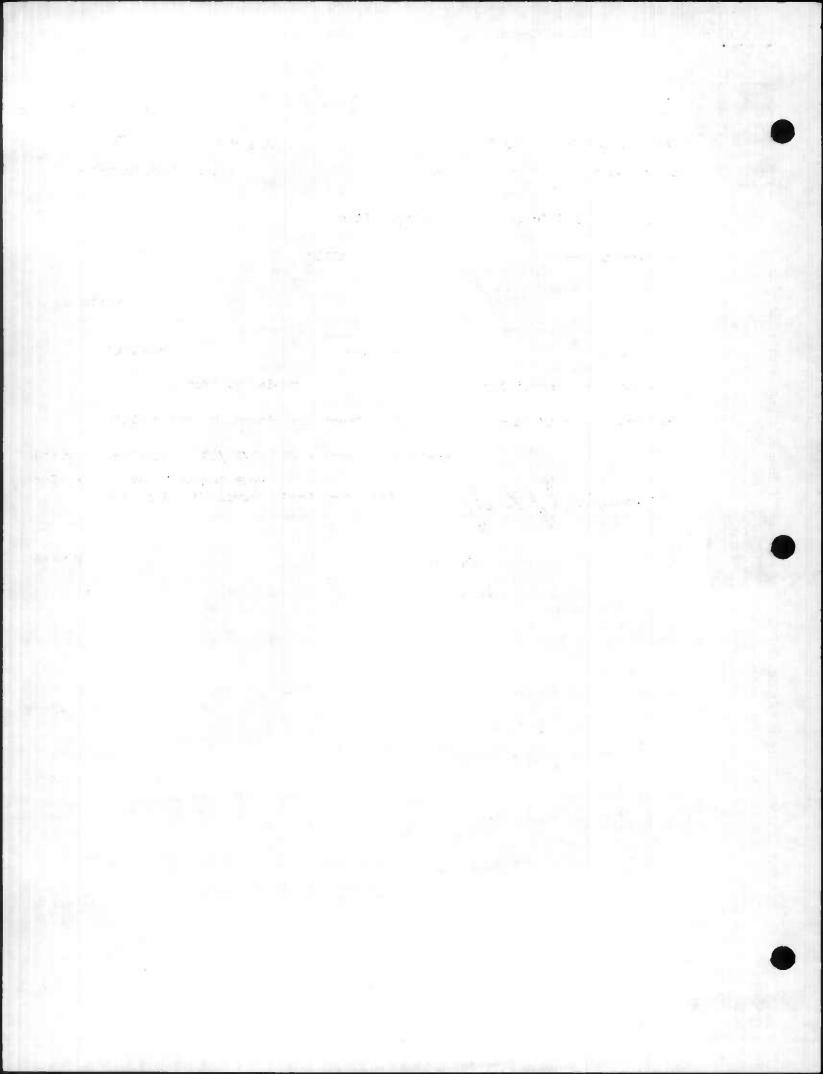


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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 305 Month **Physician** DIXON 1999 MARCH DORIS /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 8. Date of Birth (Month, Day, Year) Dec. 6, 1916 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Maryland 1 M 2 F 215-22-0602 82 Yrs **Director** Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Owings Mills Directo Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Lastgate Road 21117 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: White py 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mentel Hygient Important: If them 27 is marked other that sny Injury or other traumette 12 Secretary Automobile 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fortmiller Mamie Ε. Musch German Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Name/Relationship (Type, Print) 4 Ratna Court Baltimore, Maryland 21236 Mrs. June B. Mohr/Niece 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removel from State 3/17/99 Parkville, Maryland Moreland Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Servica Licanses Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or count icetions that call to the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on ear limb. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in deeth) SUSTOLE 10 days Examiner Due to (or es a consequence of) Examiner EMORRAGHE 10 DAYS NTRACEREBRAL certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pue Due to (or as e consequenca of): physician Box 68760 Physician/Medical the Due to (or es e consequence of): as 980 for ed by the e 23b. Did tobecco use contribute to the cause of deeth? P.0. Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown RENAL ANCER Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to Completed completion of cause of death? hes 1 ☐ Yes 2 No certificete Division of Vital I Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 2 Accident 5 Pending efter death. Director: Aft 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ò Hospital 24 hours 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and menner as stated. edicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F within 2 29b. Signature end title of certifier RELIDENT 29c. License number 29d. Dete signed (Month, Day, Year) Wohn PHYSICIAN RES - 000 ms 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) BALTIMORE HOPKINS HOSPITAL JOHN ms 2441010 31. Date filed (Month, Day, Year) 22. Registrar's Signature

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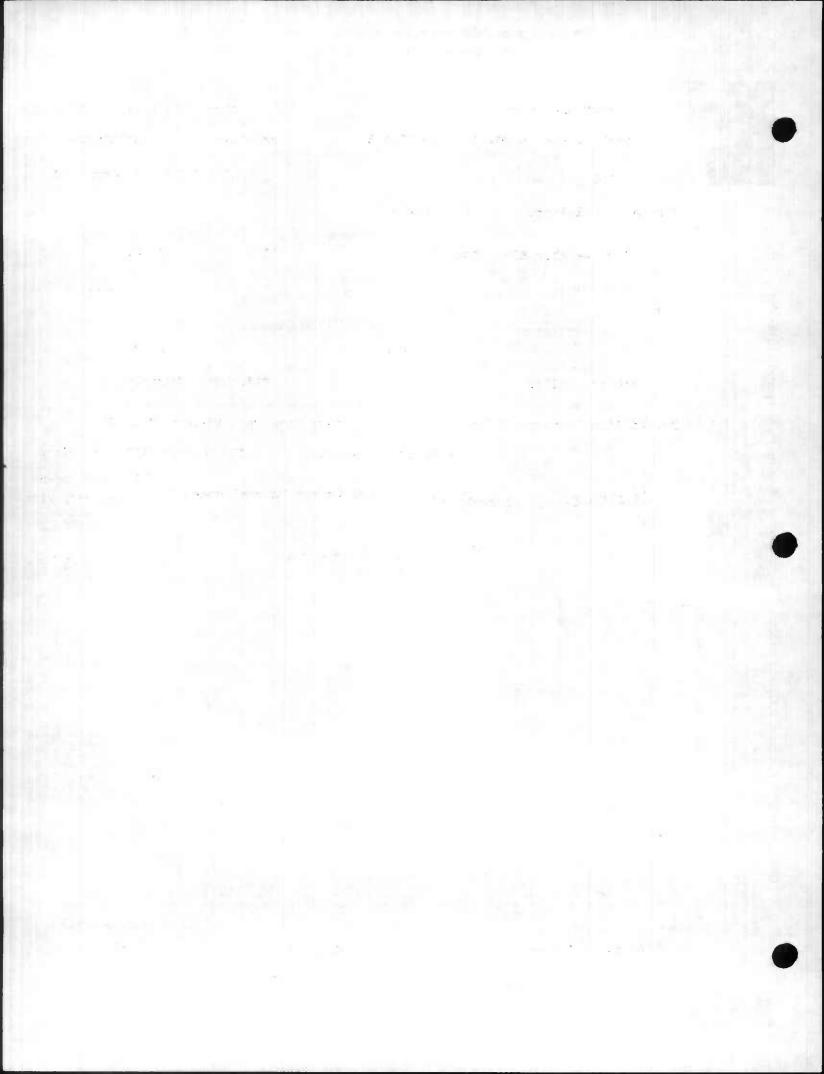
State Registrar



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State of Maryland / Department of Health and Mental Hygiene

		Olato of Maryle		Certificate of		Monda 11	Reg. No.	08295				
1-1-1-1	1. Decedant's Name (First, Middle, Las	st)				2. Date of De	ath	3. Time of Death				
Physician /Medical	Mary Ann	Durm				March		10:40 AM				
Examiner	4a Facility Name (If not institution, give				4b. City, Town, or	Location of Deat	h 4c. County of	Death				
		er Blvd. Apt				ville		ltimore				
Funeral Director	5. Social Security Number 6. S 220-05-8301 Usual Residence of Decedent	ex 7. Age (In your 7. 7. 9	rs. last birth	Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country) Maryland				
t 28a-f show	10a. State 10b. County Maryland Baltimo		City, Town o	or Location kville				10d. Inside City Limits 1 ☐ Yas 2 No				
th with the Mai 23e or 28e-f e	10e. Street and Number 8820 Walthe	er Blvd. Apt	414 1	10f. Zip Code Bldg 3	2123	34	U. S. A.	et Country?				
d 21215-0020 flied within 72 hours after death with the Maryland Hygiane. Hygiane. Inter than "natural", or items 23s or 28s-f show not, its Medical Exercices must be notified at Completed by Funeral Director	11. Marital Status 1 Navar Marrlad 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U,S.	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes ※☐ No		Specify Yes or No to Rican, etc.)		Amarican Indian, White, etc. White				
1 21215-0020 led within 72 hours af bygiene from their trains that the from the trains the trains that the from the trains the trains that the from the trains that the trains the trains that the trains that	15. Decedent's Ed (Specify only highest gra	de completed)	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	pation during most of wo d)	rking	16b. Kind of Bush	nass/Industry				
d 212. filed within Hygiene. wither then ent,	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemaker			Own Ho					
B saby B	17. Father's Name (First, Middle, Last) Albert Mill						, Meiden Sumeme) Zuschlu					
fary 2 shou and N	19a. Informant's Name/Relationship (Type, Print)	19b. l	Mailing Address (Street	end Number or R	ural Route Numb	er, City or Town, St	ete, Zip Code)				
	Dr. William B. Du				s Farm W							
	Dr. William B. Durm, IV(Son) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Parkwood Cemetery 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Parkwood Cemetery 3-17-99 Parkville, Mary											
Baltimo permit. Page: Department of Important: If is any injury or once.	21. Signature of Funeral Service Lican	C R. R.	1	22. Name and Addre		ral Homo	105 e, Inc	O York Road son, Md. 21204				
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Physician	snock, or near failure. List only	one cause on each line.						Interval Between Onsat and Death				
/Medical	Immediate Cause (Final disease or condition Metastate Melanoma											
Examiner	resulting in death)	a		nsequence of):				3				
nsit		b										
I Records, P.O. Box 68760, The law requires that the death certificate be executed tate has been signed by the attanding physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
68760, tificate be ex g physician as the burial	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
Box auth certing attending for usa a	d											
Geath death of for set	Part II. Other significant conditions of	ontributing to death but not r	resulting in t	he underlying cause gi	ven in Part I.	23b. Dld	tobacco uae contr	ibute to the cause of death?				
IS, P.O. Box as that the death cert igned by the attending be detached for use. by Physician/M								☐ Probably 4☐ Unknown				
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The law require tate has been sippage 2 should Completed						pen	ormad?	completion of cause of death?				
						10	Yes 2 No	1 ☐ Yes 2 ☐ No				
f Vital Fysician: The ysician: The scarificate director, pag	25. Was case referred to medical examiner?					ath (Check oply	one)					
T digital	1 ☐ Yes 2 ☐ No		☐ ER/Outp	atient 3L DOA	her: 4 Nursing I	-	idence 6 □Other					
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Divisor Atta after de Directo d'in by ti	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, fam	n, street, factory, office			(Street end Number wn, Stete)	or Rural Route Number,				
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Alter I completely filled in by the funara Medical Certification:		ysician: To the best of my k niner: On the basis of exami and manner stated.										
To the comp	29b. Signature and title of certifier			29c. Licans	se number		29d. Date signed (Month, Dey, Year)				
	white			93	2048		3/15/9	9				
3)	30. Name and address of person who	completed cause of death (I	tem 23a) (T	ype, Print) FITOM AUS	- OUT M	d 212	2.4					
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	21012 4 1100	1	01 -12	-					
• Registrar	MAR 1 7 199	9 Sprewa	B.	Sporks	/							



1. Decedent's Nama (First, Middle, Last) 2. Date of Death Day **Physician** : MARTINO DAWN MARCH 13,1999 8:43PM /Medical 4a. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE TOWSON If Under 24 Hrs. 8. D. MEDICAL CENTER If Undar 1 5. Social Security Number 7. Aga (In yrs. last birthday) 6 Sax 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 M Months Days Hours Min 218-90-4118 Director 6,1963 Usuel Residence of Decedent the Menylend 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? NASCO PLACE 5707 21239 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Ever in U,S. Armed Forcas? 11. Marital Status t Never Married 21 Married 1 ☐ Yes 2 No 1 Yes 2 1 No Specify: à 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) WATTRESS 12+4 RESTARAUNT Chain NIM permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic important: if item 27 is marked other 1 any Injury or other traumatic event. In 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be KLINE NORMA 2 HENRY Weber 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) MARK J. D. MARTINO (HUSband) 5707 PLACE BAUTS. MD NASCO 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removel from State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Kosary, Cem.

22. Name and Address of Facility

HARTLEY MILLER

Physician /Medical Examiner

the buriel-trensit

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page 2 certificate has

in by the

peed

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice

To the Hospital or within 24 hours eff To the Funeral Di completely filled in

end

P.O. Box 68760,

Records,

Division of Vital

Simartino,

Examiner Physician/Medical þ Completed Be 2 Medical Certification:

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examinar?

1 Yes 2 No

27. Manner of Deeth

Natural

2 Accident

3 Suicida

29a. Certifier

4 - Homicide

Immediate Ceuse (Final

disease or condition resulting in death)

4 ☐ Donation 5 ☐ Other (Specify)

2t. Signature of Funeral Service Licansee

ENDSTAGE LIVER DISEASE Due to (or as a consequenca of):

Dua to (or as a consequence of):

↑ Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, straet, factory, offica building, etc. (Specify)

28b. Time of

Holy

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Dey Yeer)

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No

24e. Wes an autopsy

24b. Were eutopsy findings available prior to completion of ceuse of death?

Approximate Interval Between Onset and Death

3. Time of Death

Birthplaca (State or Foreign Country)

10d. Inside City Limits 1 Tes 2 No

BALTIMORE

U-S-A

Specify:

21239

BALTO. MO

HOME

14. Raca - American Indian,

WhITE

Black, White, etc.

MARYLAND

1 Yes 2 No

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

3/18/99

Funeral

BALTO

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Dey, Yeer)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) N. Charks Suitz 407 Beltimore MD, 21204 6569

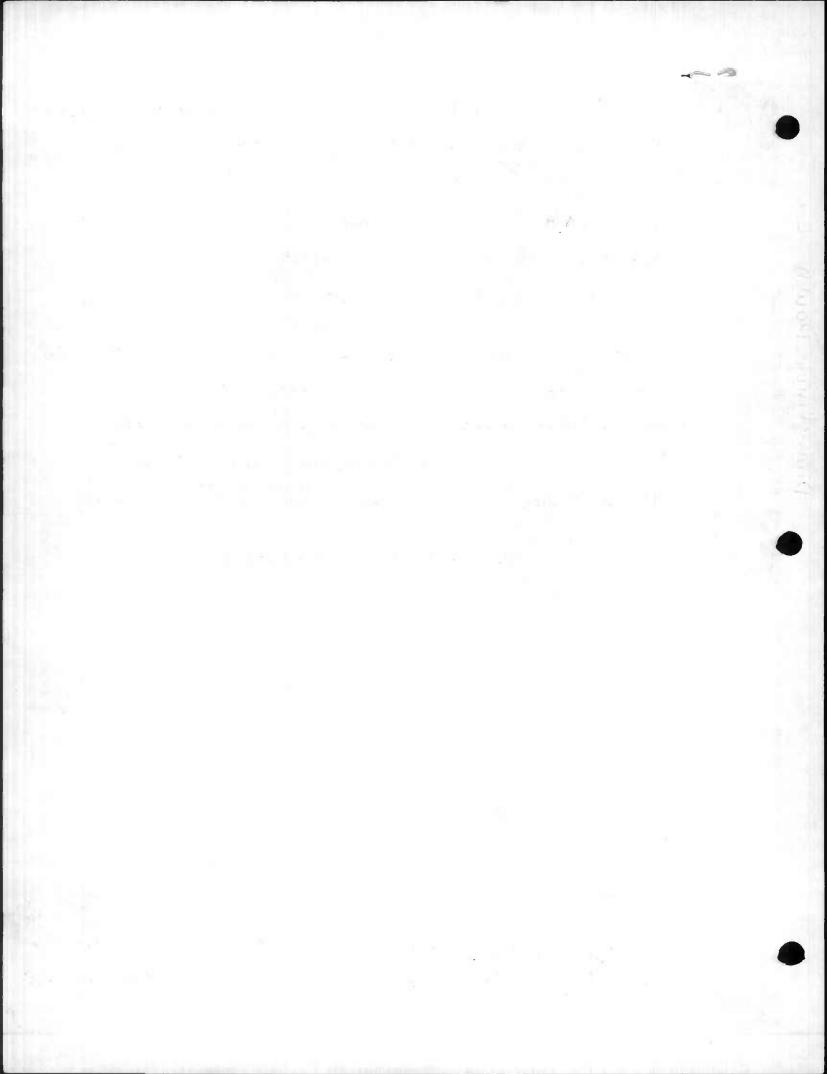
JANE 31. Date filed (Month, Day, Year)

> 7 1

1999

32. Registrar's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item#18 perFHG770 4/1/99 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** E. Debus March 14, 1999 1310 /Medical 4a Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Ctr. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) **Funeral** Months Days Hours 1□M 21 F Director July 11,1914 214-56-6124 84 Ohio Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Maryland Anne Arundel Severna Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 43 West McKinsey Road 21146 United States Apt. 104 Norma 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [3] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Merital Status Bleck, White, atc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: à 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed w f Health and Mental Hygler tem 27 is marked other th 12 Years Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Mary Caroline Burke Burk Vernon Eugene Tweed 19e. Informant'a Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau Mr. Ronald N. Debus/Son 2000 Bulls Sawmill Road Freeland, MD 21053 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Oak Lawn Cemetery 3/18/1999 21. Signeture of Funerel Service Licenses 22. Neme and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart leilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel CARCHOMYO disease or condition resulting in death) years Examine Examiner 1802 the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of): USB Pert II, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? O 1 Yas 2 No 3 Probably 4 Unknown 6 0 Records, þ The law requires 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai 25. Was casa referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Attending 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 5 Pending investigation 1 | Yes 2 | No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, atreet, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Deta signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

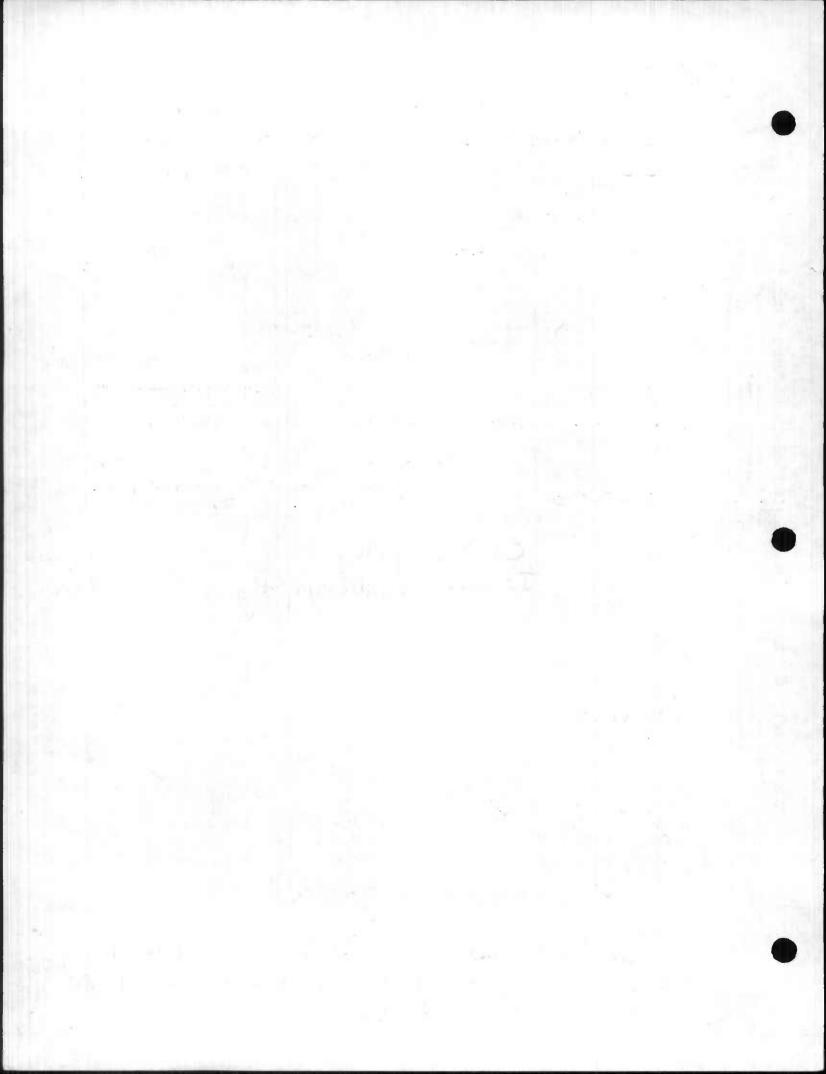
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Suite 300

ceuse of death (Item 23a) (Type, Print) 900

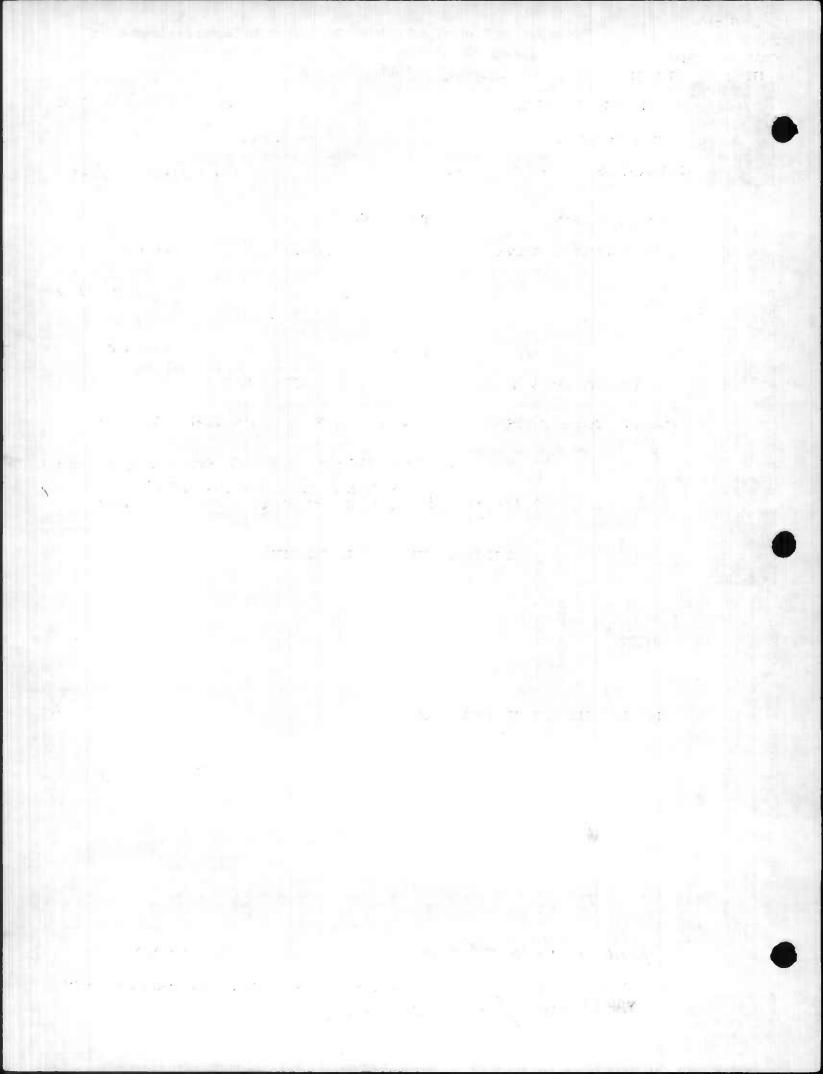
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Physician · /Medical	PART I, II, 27 PER 1. Decedent's Neme (First, M BENNIE I	iddle, Last)	GGS	-75 811.					2. Date of D Month March	10, Dey 19	99 ^{Yeer}	3. Time of Death 9:07	
Examiner	4e Fecility Neme (If not Institu		reet end nur	n <i>ber)</i>			4t	Baltimo			ty of Deeth		
Funeral Director	5. Sociel Security Number 220–64–6152	45	M 2□F	7. Age (In yrs 40	. lest birthday) Yrs.	If Under 1 Ye Months De		If Under 24 Hrs Hours Min	(Month, L	Sirth (Dey, Year)		plece (Stete or Foreign intry) YLAND	
nyland show	Usuel Residence of Decedent 10e. Stete 10b. Cou	inty		10c. C	ity, Town or Lo							10d. Inside City Limits 1% Yes 2 □ No	
the Me	MARYLAND I	N/A			BALTI	MORE 10f. Zip Cod	le			10a. Citizen o	10g. Citizen of What Country?		
th with	1743 CLIFTV	IEW A	VENUE					213		U.S.A			
72 hours effer death with the Meryland **natural**, or flame 23a or 28a-f ahow fidial Examiner must be notified at eted by Funeral Director		Married	2. Wes Dece Armed Fo 1 Pes If Yes, Giv Yeer or De	2 No		Wes Decedent of If Yes, specify C 1 ☐ Yes 2 1	uban	spenic Origin? (5 n, Mexican, Puel Specify:	Specify Yes or Note Rican, etc.)	BI	ack, White	ican Indien, , efc. -AMERICAN	
- 1 M	15. Dece (Specify only hig	-			16a. Deced	16a. Decedent's Usuel Occupetion (Give kind of work done during mo- life. DO NOT use retired)			rking	16b. Kind of	Business/Ir	ndustry	Ī
be filed within itel Hygiene. d other than ovent, the Mac	8TH (0-1		College (1	PLUIMER P						PLUN	BING		
permit. Peges 1 and 2 should be filed within Depertment of Heelith and Mentel Hygiene. Important: If flem 27 is marked other than any injury or other traumatic event, the Mence. To Be Comp									me (First, Midda HALJ	le, Maiden Suma	me)		
d2 sho th and 7 is ma traum	19e. Informent's Name/Relati		e, <i>Print)</i> SISTE	D	19b. Meiling Address (Street end Number or Rural Route Number, City or To 534-N. DECKER BALTIMORE, MD.							-	
of Heel Nem 2	JOSELYN COLES 20e. Method of Disposition			20b. Plece of Disposition (Neme of complete comp						T	MD. 21205 ocation - City or Town, Stete		
ment chart if	4 Donetion 5 Other (Specify) MI ZION CEMETERY MARCH 19,1999 BALTIMORE										MARYLAND		
Dependit	22. Signeture of Funerel Service Licenses 22. Name end Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME												
	200 Part Favorite disease)· 1	CARL	- M//									
	23e. Part1. Enter the diseese shock, or heart failure.	, or complica List only one	ations thet co ceuse on e	aurochhe dee am line.	oth. Do not ent	412 E. ter the mode of	PR	ESTON S	T. BATIN	O, MD. errest,	2121:	Approximete intervel Between	
Physician /Medical Examiner	Immediate Ceuse (Final diseese or condition resulting in death)	e		ENDOCAI Due to (eth. Do not ent	ND ACUTE 1 quence of):	PR dying	ESTON S , such es cardle	T. BATIN	O, MD. errest,	2121:	Approximete	
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Registrar

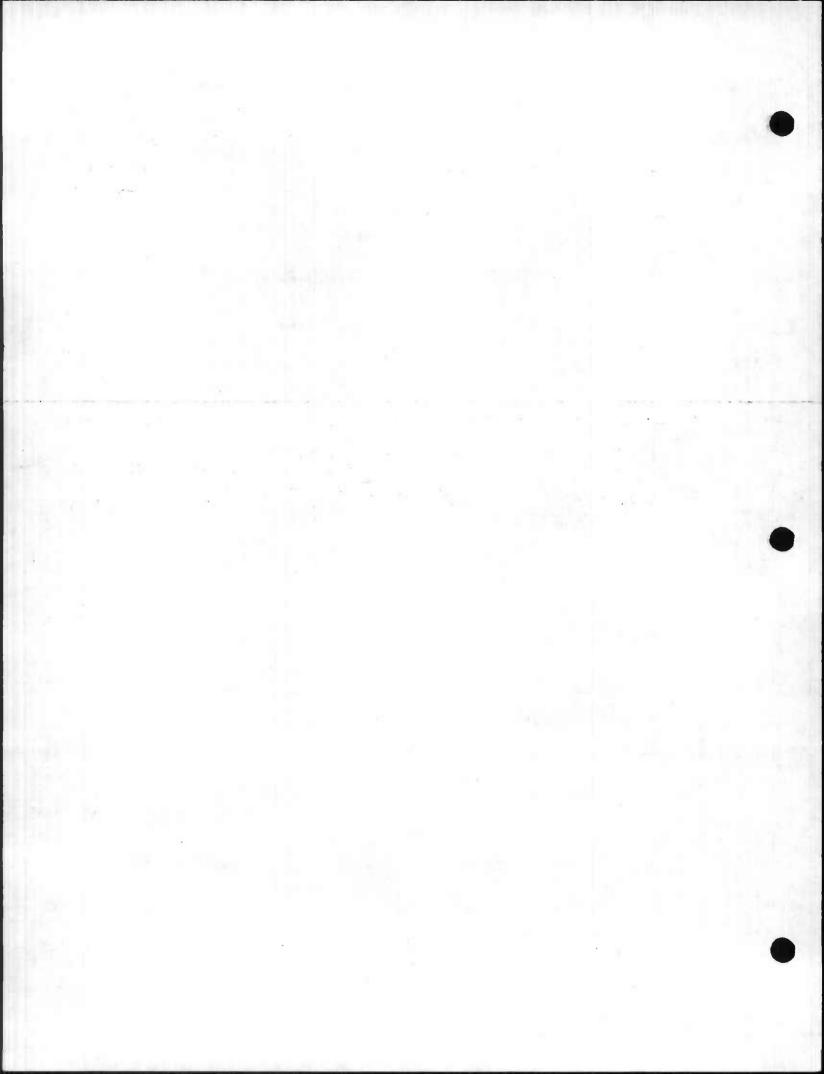


Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\)

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 13, WILLIAM T. FRANCIS 1999 MAR. 5:15 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES NURSING & REHAB. ELLICOTT CITY HOWARD COUNTY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 15, 9. Birthplace (State or Foreign Country) 1928 WASHINGTON 7. Age (In yrs. last birthday) Funeral Daya Hours 10M 20 F Montha 70 579-34-4787 **Director** Usual Residence of Decedent DC 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No MD. HOWARD Director COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 9630 BASKET RING RD. 21045 U.S.A. Herrs 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important; If New 27 is marked other than "rent in fury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) DENTIST DOCTOR 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JESSE FRANCIS CALLIE CLORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addresa (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PRISCILLA FRANCIS/WIFE 9630 BASKET RING RD. COLUMBIA, MD. 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE WASHINGTON CREMATORY
22. Name and Address of Facility 3/19/99 LAUREL, MD. 21. Signature of Funeral Service Licensee CHARLES S. ZEILER & SON, INC. 23a. Part I. Egy if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Thrombuses disease or condition resulting in deeth) Examiner Examiner nepstive physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Que to (or as a consequence of): MOCNGIZI Box 68760 Physician/Medical Due to (or as a consequence of): 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 TYes Prexteh Mcks blic to bon Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed NSPORL No No 20 No sikusm. 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) 1□ Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific CS) edical Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury bodurred Natural To the Hospital or Attending 5 Pending investigation 1 Yea 2 No hours after death. Director: / 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerei Direc completely filled In by 4 \ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner ea stated.

2 Regical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of curtifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) tes ma N 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 17 MAR Registrar

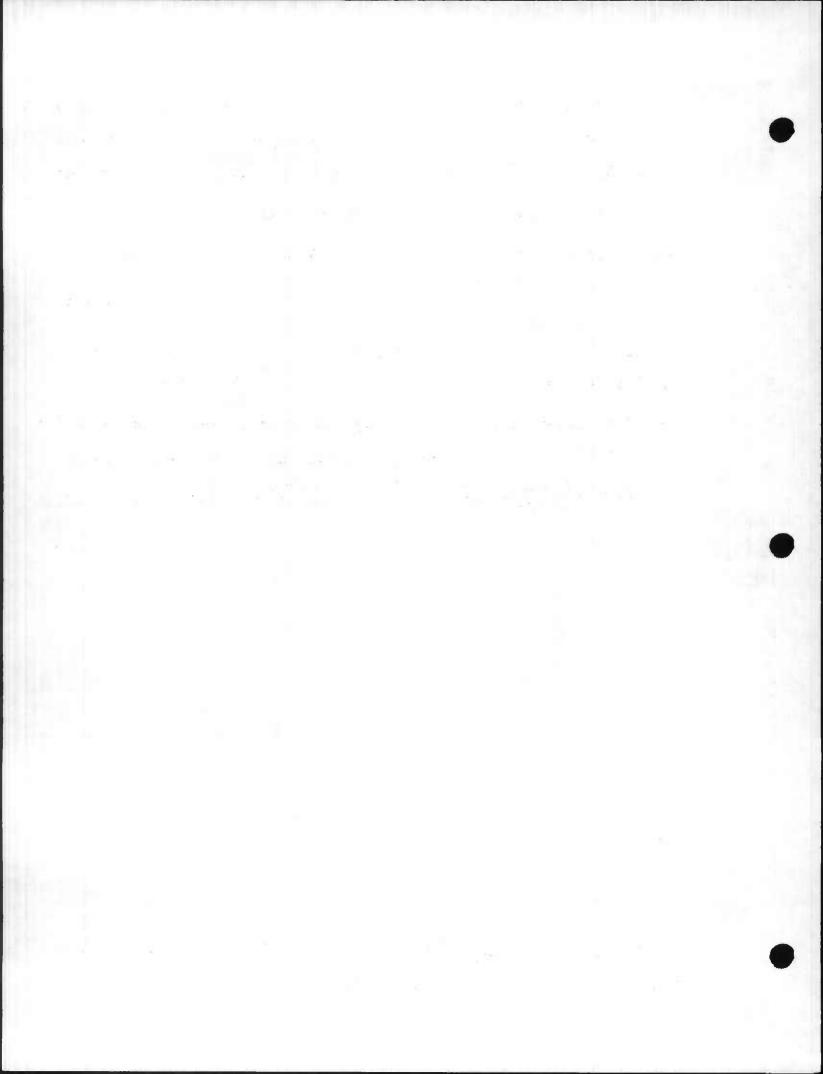


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State of Maryland / Department of Health and Mental Hygiene

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				Ce	ertificate o	f Death		Re	eg. No.	U	0000			
		1. Decedent's Name (First, Middle,						2. Date of Deet Month		Year	3. Time of D	eath		
	Physician /Medical	Joan	Ruth Fillm	ore				March	14,	1999	10:35	PM		
	Examiner	4a Facility Name (If not institution,						ation of Deeth	4c. Coun	ty of Death				
		Genesis Elde	rcare				ipoli			e Ar	undel			
	Funeral Director	5. Social Security Number 219-32-3953	S. Sex 7. Age 7. Age	(In yrs. last birthday 61 Yrs.	Months Dey		Min.	8. Date of Birth (Month, Day, JAN 15,	Year) 1938	Cou	plece (Stete or I ntry) yland	Foreign		
	pu s	Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town or L	ocation						10d. Inside City	Limits		
	with the Maryland a or 28a-1 show Libe notified at		Annes			ensvi	11e				1 ☐ Yes 2			
	ifer death with the Ma r flems 23a or 28a-1s infermulation noting Funeral Director	10e. Street end Number 606 Bayside	Drive		10f. Zip Code	21666	5	10	0g. Citizen of Ui	What Cou				
	keme 23	11. Marital Stetus	12. Was Decedent Ev Armed Forces?	er in U,S. 13.	Wes Decedent of	Hispenic Or	igin? (Spec	city Yes or No-		ace - Ameri				
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Maryland 21215-0020	led within 72 hours ygiene. nor than "natureit, nt, tre Medical Exit. Completed by	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usuel Occ e kind of work don	e during mos	st of workin	ng	16b. Kind of	Business/Ir	ndustry			
12	y within r than tra Men	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use reti	гөа)			Bro	kera	σ _O			
d 2	be filed within tal Hygiene. Id other than event, tra M. Be Comp	17. Father's Name (First, Middle, L	ast)	Han	адсі	18. Moth	er's Name	(First, Middle, N			50			
lan	W Segw	William Well	,					E. Mat						
ary	d 2 should the and Men 7 is marke traumatic	19a. Informant's Name/Reletionshi	p (Type, Print)	19b. Mail	ling Address (Stre	et and Numb	er or Rural	Route Number	City or Town	n, State, Zi	p Code)			
		David Fairba	nk/Friend	606	Baysid	e Dri	ve S	Stevens	sville	e, M	D 2166	6		
ore	5 5 2	20a. Method of Disposition 1 ☐ Burial 2 X Cremation	Personal from State	20b. Placa of Disp					20c. Location					
Ĭ.	Pages ment of ant: If its ury or o	4 Donation 5 Other (Spe	ecify)	Metro C	remator	y, Ir	ic. 3/	15/99	Balt:	imor	e, MD			
Baltimore,	permit. Page Department of Important: If any injury or once.	21. Signeture of Funeral Servica Li	Tregochet	C	rematic	on So	ciety				D 0100	. 0		
		23a. Pert1. Enter the disease, or conshock, or heart failure. List o		ne death. Do not er	99 Fred	ying, such es	cerdiac or	r respiratory arre	LIMOR est,	e, m	Approximate			
	Physician	snock, or near failure. List o	my one cause on each line							- !	Onset and De	ath		
	/Medical	Immediate Cause (Finel disease or condition		Lun	Conce						6M			
	Examiner	resulting in death)) e	ue to (or as e conse										
Н	a is a		b .											
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Records,	been s should							24e. Wes en		9	Vere autopsy fin- veilable prior to ompletion of cau f death?			
R	The law ate has page 2							1 □ Ye	s 2 No	1	☐ Yes 2☐ N	0		
Vital	certificate rector, pag	25. Was case referred to medical				26. Place	e of Death	(Check only on	e)					
f \	S S D	exeminer? 1 ☐ Yes 2 X No	Hospitel: 1 Inpatient	2 ER/Outpetie	ent 3 DOA	Other: 4 X N	ursing Hom	ne 5 Reside	ence 6 🗆 O	ther (Speci	ify)			
O L	ding Phy h. After thi funeral	27. Manner of Deeth 1 XNatural 5 ☐ Pending	28e. Dete of Injury (Month, Day	(ear) 28b. Time Injury	N N	jury et /ork?	2	8d. Describe ho	ow injury occi	urred				
sio	Attending or death. Ctor: After by the fune lification	2 Accident Investiga 3 Suicide 6 Could no	t he			☐ Yes 2☐								
Division of	tal or Attending P rs after death. st Director: After ti led in by the funera Certification:	4 Homicide determin	ed 28e. Pleca of Injury building, etc.	y - At home, farm, s (Specify)	treet, factory, offic	æ	2	8f. Location (St. City or Town		n <i>ber</i> o <i>r R</i> ui	el Houte Numbe	31,		
	pital ours a sure a sur	29a, Certifier 1 X Cartifying	Physician: To the best of		Ab a second of the	Aime data a		and about a the size	(a) and a		atata d			
	To the Heapital or Attend within 24 hours after deatt To the Funeral Director: completely filled in by the Medical Certificat		caminar: On the basis of e end manner state	xamination and/or is										
	Vithin Fo the comp	29b. Signature and title of cartifier			29c. Lice	nse number		2	9d. Dete sign	ned (Month	Day, Year)			
		▶ 9\ () \ \	24141	MD	1	320	26		March	15	1999			
	. 0	30. Neme and address of person	ho completed cause of dea	th (Item 23e) (Type	, Print)	-	Λ .							
	V	Gast Enra	re 2108	D. Dm.	to Briv	e C	herte	. M	2/6	19				
	State	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Ina	dal								
	Registrar	MAR 17	1999	la.	13000	A. C.								



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death OS An Month 03

Physician /Medical **Examiner**

Funeral Director

death with the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours after t. Pages 1 and 2 should be filed w tment of Health and Mental Hygle tant: If item 27 is marked other to jury or other traumatic event, to permit. Page Depertment of Important: If any Injury or

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

of Vital

Division

Physician /Medical Examiner

The law requires that the deeth certificete be executed the burial-transit for use as signed by the e page 2 should certificate or Attending Physician: s after deeth.

I Director: After this of in by the funeral d this Hospital To the Hospital
within 24 hours a
To the Funeral Completely filled

Physician/Medical Examiner ģ Completed Be 2 Certification:

4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 6600 Ridge RU 4c. County of Death HCR/MANOR 5. Social Sacurity Number Rossville 4 IMORE If Undar 1 Year if Undar 24 Hrs. 7. Aga (In yrs. last birthday) 6. Sax Birthplace (Stata or Foreign Country) 1X M 2□ F Months Days 84 Yrs. 215-03-6265 1914 Maryland Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Director 1 Yas 2 No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 7591-C Ives Lane 21222 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Maritai Status 1 Navar Married Married 1 ☐ Yas 2 ☒ No Specify: g Specify: White 3 Widowed 4 Divorced Be Completed Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grade complated) Elementary/Secondary (0-12) Collage (1-4or 5+) Clerical Accounting 12 Procter & Gamble 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Albert Foster Mary Jane Gray 19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 7591-C Ives Lane Inez Foster/Wife Dundalk, MD 21222 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 3/17/99 Baltimore, MD 22. Nama and Addrass of Facility
Cremation Society of MD, 21. Signature of Funaral Sarvice Licensee 0 le Edward 299 Frederick Road Baltimore, Gregorchik MD 21228 23a. Pert1. Entar tha disaasa, or complications that causad tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haert failura. List only ona causa on aach line. Approximata Intarval Batween Onsat and Daath Immediete Causa (Final roke disaasa or condition rasulting in daath) Mos. Dua to (or as a consaquance of): Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Cause (Disaasa or injury thet initiated events rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not rasulting in tha underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of daath? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medicei 26. Placa of Daath (Check only ona) axaminari Other: 4 Aursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Naturai 5 Panding invastigation 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner es stated.

2 Medical Examplear: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and place, and due to the causa(s) 29a, Cartifian Medical 29b. Signatura and Hill of certif 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

17 Fontana Lane

32. Ragistrer's Signetura

man

Baltimore, MD 21237

DHMH 16 Rev 6/95

State

Registrar

Rahnama, M.D.

MAR 1 7 1999

31. Data filed (Month, Day, Year)



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Recedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** rarinacci 03:00 vieor9 March ith on /Medical City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number 4c. County of Deeth Examiner Sattimore Hospita Hopkins Johns Baltimore City If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) 6. Sex 1 M 2 F If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Director 217-09-5493 April 23, 1919 Baltimore Maryland Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yas 2 X No Directo Maryland Baltimore Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 12 Palmway Court 21013 U.S.A. Funeral death 12. Wes Decedent Ever in U,S Armed Forces? NAVA 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Merital Status 1 X Yas 2 No NAVY If Yes, Give Yaar or Datas: 12 should be filed within 72 hours aftar. 1 and Mental Hygiena. 1s marked other than "natural". or hear 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 yrs. n/a Home Builder Self-Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Antonio Farinacci Josephine Romano 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) porms. Pages 1 and 2 sh Department of Health and Important: If Nem 27 Is m Mrs. Palma Farinacci (Wife) 12 Palmway Court Baldwin, Maryland 21013 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriei 2 □ Cremetion 3 □ Removel from Stete ò 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem.Grds. 3/17/99 Towson, Maryland 21204 21. Signature of Funeral S 22. Nama end Address of Fecility any it E.F.Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087 23a. Part1. Enter no dis complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory only one cause on aech line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical 2 months Examiner Examiner egr physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest certificata be axecu P.O. Box 68760 Physician/Medical Due to (or es e consequance of): USB BS 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown osta Division of Vital Records, by 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? Completed 24a. Wes an autopsy cartificata has 1 Yes 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. injury et Work? 5 Pending Investigation 1 SNeturet 2 Accident il or Attending safter death. 2 No 1 ☐ Yes 6 Could not be determined 3 Suicide 28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stele) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and manner stated. 29a. Certifier edical (Check only one) To the I 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Street Baltimore Maryland 21887 ONG H 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State Registrar

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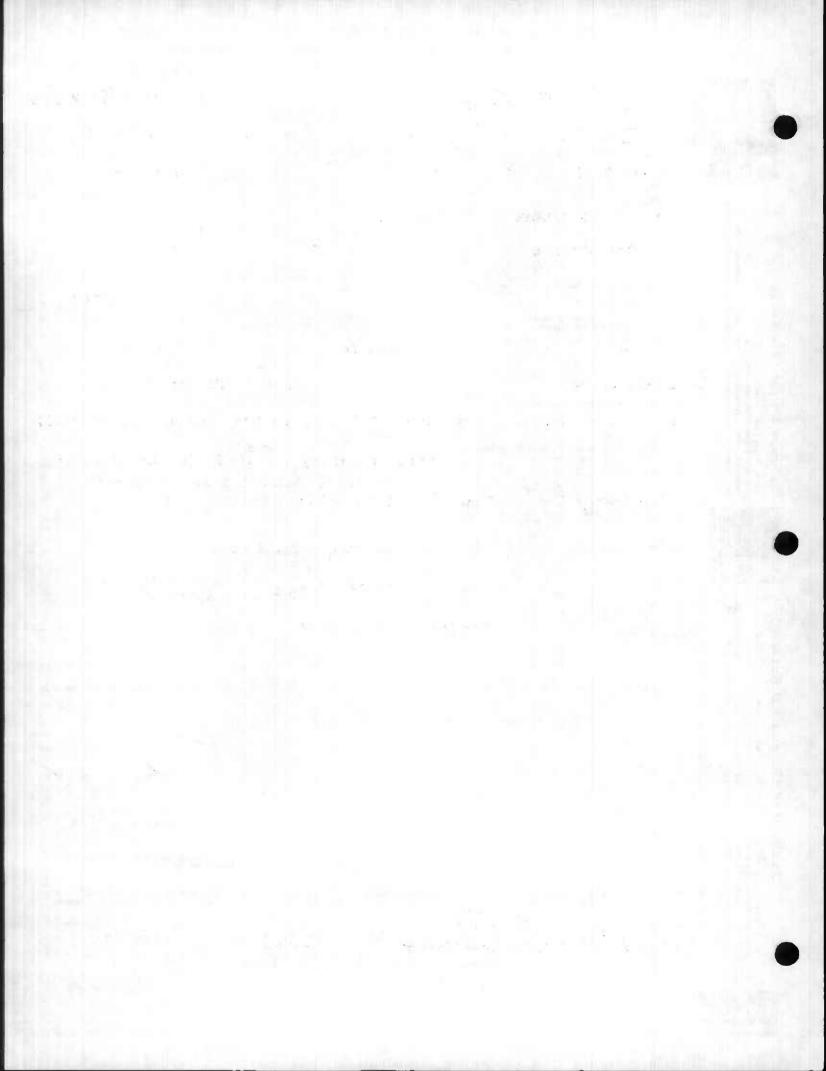
Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Eudyn Fruc 3 4:25 MM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) **Examiner** Batton Hopkiss ISCH VOOW 20425 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ☐ M 2 💢 F Yrs. 86 Director 172-22-9244 Aug 27 1912 MD Usual Residence of Decedent with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natursi", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Dundalk 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 205 Colgate Ave 21222 USA permit. Peges 1 and 2 should be filed within 72 hours efter deeth Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturs!", or items 23. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Raca - American Indian. 1 ☐ Yas 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: by White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mothar's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Lanham Isabelle Wright 19a. Informant's Name/Relationship (Typa, Print) 19b. Malling Address (Straet and Number or Rural Route Numbar, City or Town, State, Zip Code) Norma Jean Roberson /daughter 205 Colgate Ave Baltimore, MD 21222 altimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) March 17 injury or Metro Crematory 1999 Catonsville, MD 22. Name and Address of Facility
Connelly Funeral Home of Dundalk 21. Signature of Funeral Service Licensee any ir Conne oll 7110 Sollers Point Rd 21222 23a. Part1. Enter the disenta, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line. Approximata Interval Between Onsat and Death **Physician** tmmediate Cause (Final disaasa or condition resulting in death) /Medicai Examiner Examiner that the death certificate be executed hysician and the the burial-fransit Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated avants resulting in daath) Last Physician/Medical Due to (or as a consequence of 98 USB I 23b. Dtd tobacco use contribute to the cause of death? Part II. Other stgniftcant conditions contributing to death but not resulting in the underlying ceusa givan in Part I. 3 □ Probably 4 □ Unknown 1 Yes 2 No Division of Vital Records, à 8 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed hes 1 Yas 2DNo 1 Yas 2 No certificate or Attending Physician: 25. Was cese raferred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Othar: 4 Nursing Home 5 Rasidence 6 □Other (Specify) 1 PInpatient 2 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Daath 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 DNatural 5 Panding investigation efter death. 1 Yas 2 No 2 Accident the 6 Could not be detarmined 3 ☐ Sulcida 28f. Location (Straet and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) in by 4 Homleida 24 hours Hospital 29a. Cartifier 1 🗹 Certifying Physician: To tha best of my knowledga, daath occurred at the time, date and place, and dua to the causa(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar a (Check only one) within 2 \$ 29b. Signature and title of pertifiar 29d. Date signed (Month, Day, Yaar) an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bayviaw

Registrar

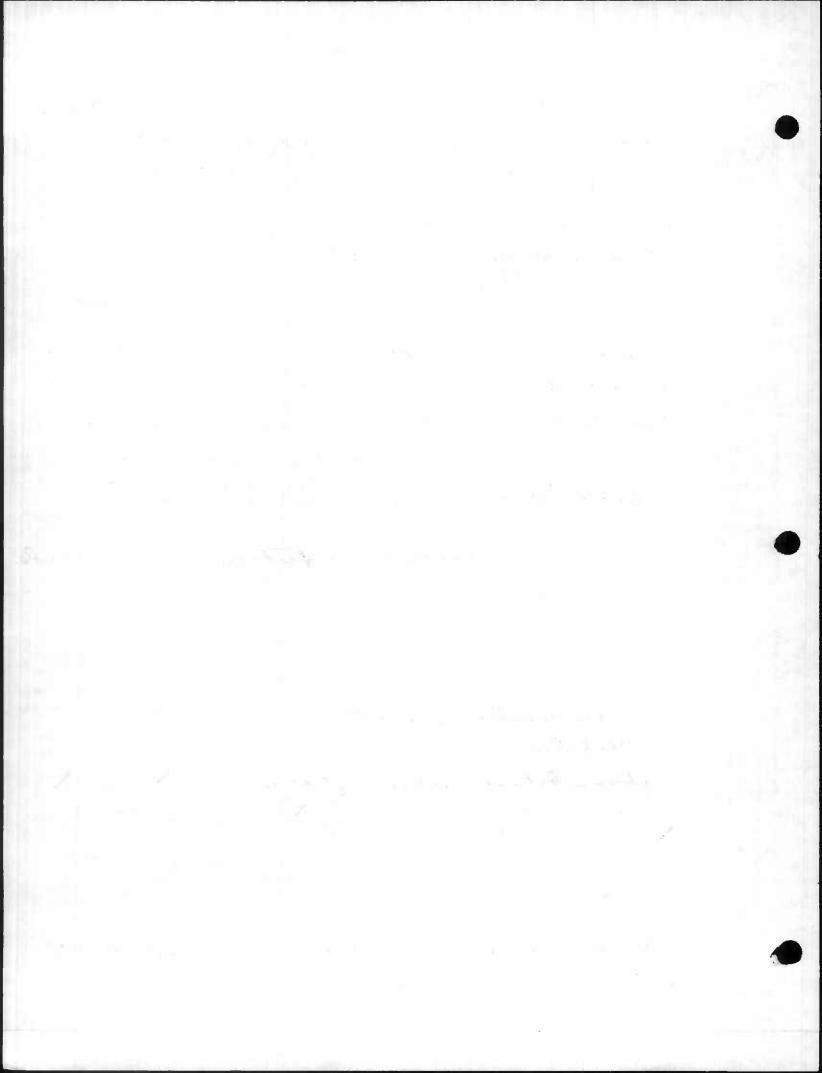
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32. Registrar's Signatura



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				State of Mary		Certifica				Reg. No. 9 9	0	830) l _i	
	Physici	an	1. Decedant's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time	of Death	
	/Medi		Elizabeth Cather:						March	14, 19		6:10) A.M.	
9	Examir	ner	4a. Facility Name (If not institution, give				2	4b. City, Town, or l	ocation of Death	4c. County	of Death			
1_			Mariner Health of			t t life in	der 1 Yeer	Forest		Hari				
	Funeral Director		5. Social Security Number 6. Security Number 1 C C C C C C C C C C C C C C C C C C	7. Age (In	yrs. last birt	rs. Month		Hours Min.	8. Date of Birt (Month, Day Jan. 3	, 1911	9. Birthp Coun Mary	lece (State try) Land	or Foreign	
	show	_	10a. State 10b. County	10c	. City, Town	or Location					1		City Limits	
	he M	ecto	MD. Harford	S	treet	1.52							95 2 No	
	23a or 3	Funeral Director	10e. Street and Number 3667 Emory Churc	h Road			Zip Code 21154			10g. CitIzen of What Country? U.S.A.				
020	be filed within 72 hours after death with the Maryland tiel Hygiena. Id other than "natural", or items 23a or 28a-f show event, the Medical Exemination notified at	þ	11. Marital Status 1 ☐ Never Marriad 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorcad	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	in U,S.			lispenic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - American Indian Black, White, atc. Specify: White				
21215-0020	hin 72 ho in *natur Wed cal	Completed	15. Decedent's Edu (Specify only highest grade Elamantary/Secondary (0-12)	cation e complatad) College (1-4or 5+)	16a.	Decedent's Us (Giva kind of s life. DO NOT	work done	during most of wor	king	16b. Kind of Bu	ısiness/inc	lustry		
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pu	tai Hy d oth	Be	17. Fathar's Nama (First, Middle, Last)					18. Mother's Nan		Maiden Sumam	Θ)			
yla	Men Men mrke	2	Frank Brodka, Jr					Anna Sr						
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	Health Health em 27 I		Diane B. Russell 20a. Method of Disposition					urch Road	Date Date	et, MD. 20c. Location -				
nor	ages int of t: If h		1 X Burial 2 □ Cremation 3 □ R	emoval from State		Disposition (A								
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		4 □Donation 5 □Other (Specify) 21. Signeture of Funeral Service License		Jarder	s of F		ss of Facility	/19/99	Baltin	nore,	Mary	land	
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			23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	cations that caused the cause on each lina.	daeth. Do n	ot enter the m	ode of dylr	ng, such as cardiac	or respiratory ar	rest,	-	Approxim Interval B Onset and	etween	
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Immediate Causa (Final disease or condition resulting In death)												
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o,	cate be executed physician and the bunal-transit	Examiner	Saquentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or Injury that initiated avants	Due t	Due to (or as a consequenca of):									
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Box	the deeth certifi y the attending ached for use es	Physician/N	d								i			
0.	by the at trached for	/slci	Part II. Other significant conditions con	tributing to death but not	resulting in	the underlying	g cause giv	en in Part I.	23b. Did t	obacco use co	ntribute to	the cause	of death?	
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Vital	Physician: this certific ral director,	o Be	25. Was casa raferred to medical examinar?	ospital:			Oth		th (Check only o					
of	E E E	-	1 Yes 2 No	1 LI Inpatient			DOA	4 LN Ivursing H	ome 5 Resid)		
Ion	Attending or death.	tion	1 Natural 5 ☐ Pending 2 ☐ Accidant investigation	28a. Date of Injury (Month, Day Yea.	r) In	jury M	28c. Injur Wor	k? Yes 2 □ No		,.,,				
Division	al or Attending P s after death. I Director: After to d in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, far	m, street, fact	ory, office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rura	Route Nu	m <i>ber</i> ,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by th	edical (29a. Certifiler (Check only one) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause of								ated. the cause	r(s)		
	To the within 2 To the comple	M	29b. Signature and title of cartifier	a number 29d. Date signed (Month, Day, Year)										
			David 5.	Su-			935	2295 march 16,1959						
4	5		30. Name and addrass of person who con	1 3		Type, Print)		- / /					-	
	Sta	te	31. Date filed (Month Par Year) MAR 1 7 10	32. Regfstrar's Si	Ignature	1	1	1				-		



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** March 3, 1999 6:00 PM MARY DUNLAP FULTON · /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 818 MARCIE COURT BEL AIR, MARYLAND AIR HARFORD If Under 1 Year | If Under 24 Hrs. 5. Societ Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthptece (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F Months Devs Hours Yrs. Pennsylvania Director 215121654 80 yrs. 09/29/19 Usuet Residence of Decedent 10e State 10h Counts 10c. City. Town or Location 10d. Inside Ctty Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 818 Marcie Court 21014 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No tf Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or Noti Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritel Status permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or ther any Injury or other traumatic event, the Medical Examina-Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elemantery/Secondary (0-12) College (1-4or 5+) Self Employed Antique store 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Nema (First, Middla, Last) Be Mary E. Morgan Alexander G. Dunlap 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 818 Marcie Court, Bel Air, Maryland 21014 Mitchell G. Fulton/son 20b. Ptece of Disposition (Name of 20e. Mathod of Disposition 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Nade, Director Ronald S State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each tina. Approximate Intervel Between Onset end Deeth **Physician** ASENOCARCINOMA of COZON /Medical Immediata Ceuse (Final disease or condition resulting in deeth) Examiner Examiner attanding physician end I for usa es the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Causa (Disease or injury that initieted events resulting in deeth) Lest Due to (or as e consequance of): Physician/Medicai Due to (or es e consequence of) signed by the a Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No LIVER METASTASES 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel axeminer? Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2√2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Mannar of Death 28e. Dete of tnjury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 2 Accidant 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendity within 24 hours after death.

To the Funeral Director: A completely filled in by the formal completely filled in the formal co investigetion 3 Suicide 6 Coutd not be datamined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Ptace of tnjury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicide Certifying Physician: To tha best of my knowledga, daath occurred et the time, dete end plece, and dua to tha causa(s) and mannar es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the fime, date end place, end due to the ceuse(s) end menner steted. 29a. Cartifian Medical (Check only 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certified 29c. License number D31775 03/07/99 30. Name and eddress of person who completed cause of deeth (ttem 23e) (Type, Print)

2112 Bel Air Road, Fallston, Maryland 21047

Registrar

Joan P

31. Dete filed (Month, Day, Year)

Edwards M.D.

7

32. Registrer's Signature

DHMH 16 Rev 6/95

the Marylend

death

Baltimore, Maryland 21215-0020

tha death certificata be executed

P.O. Box 68760.

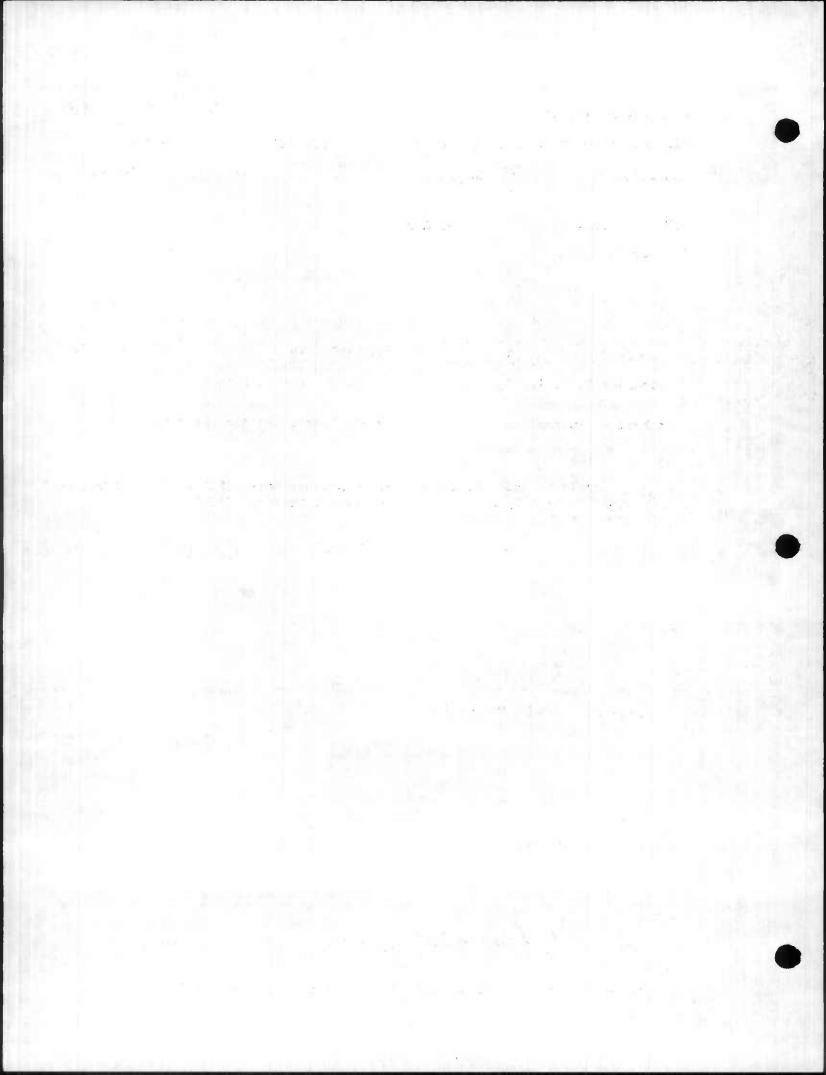
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Division of Vital Attending Physician:

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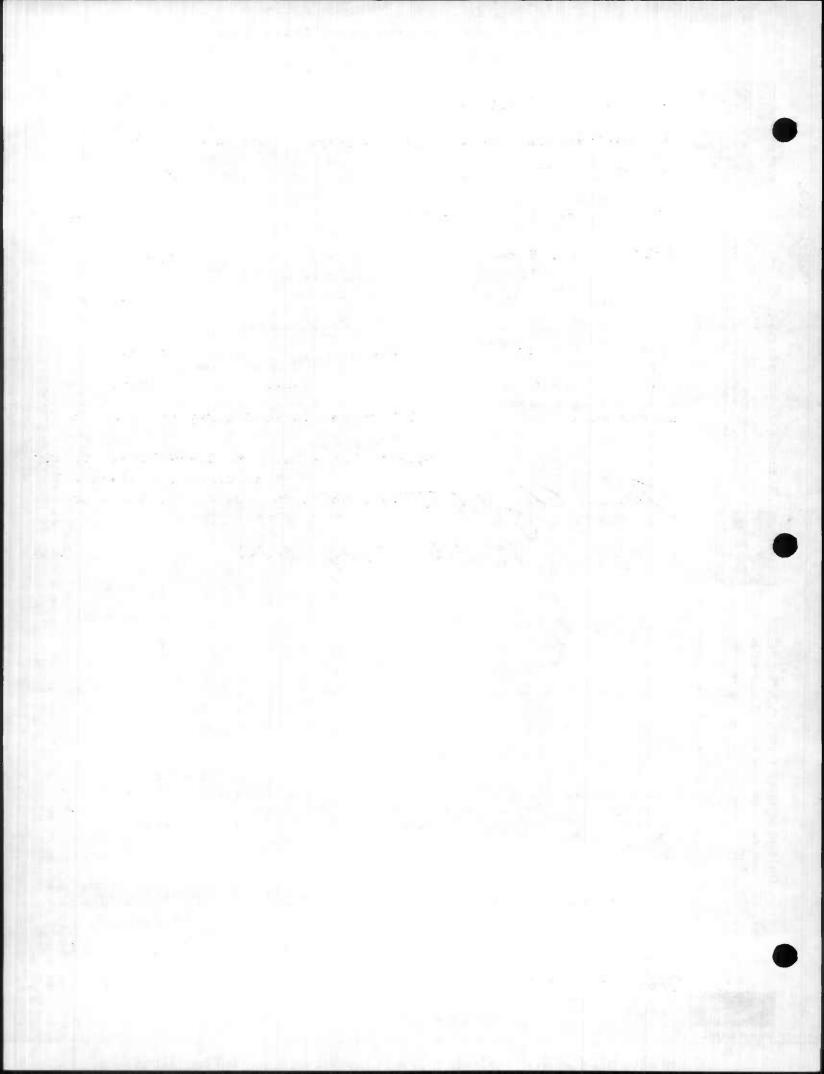
death.



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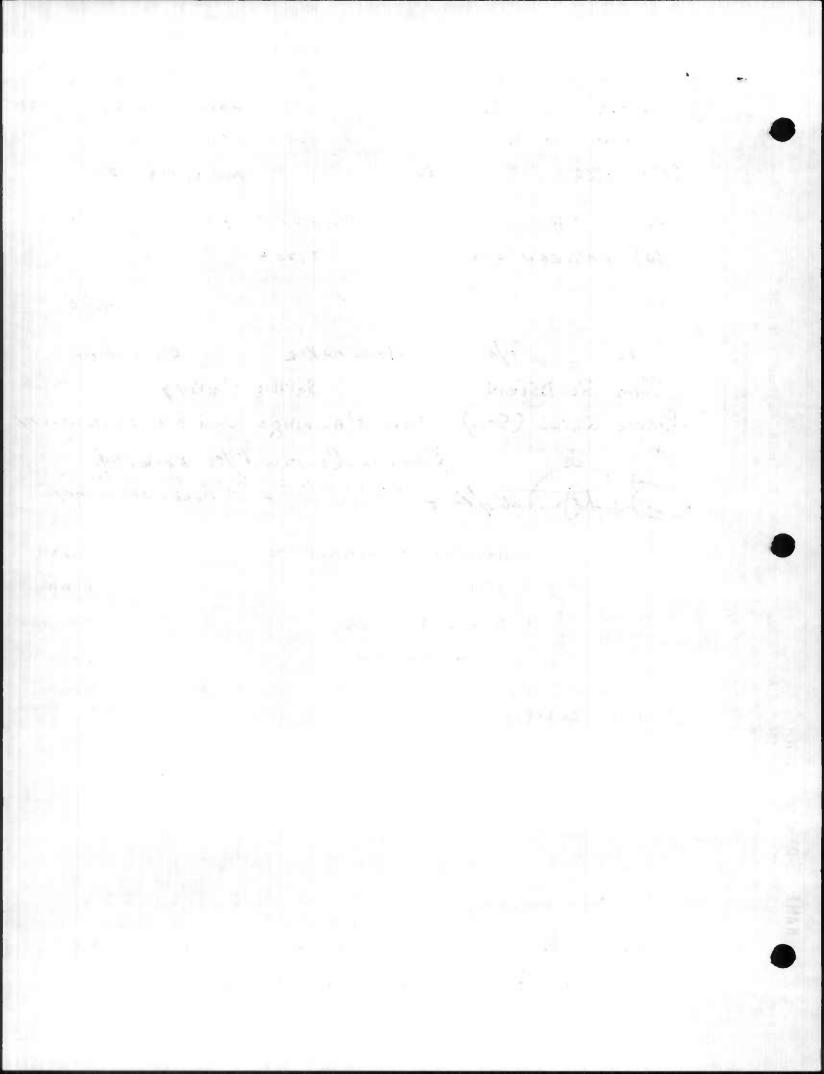
State of Maryland / Department of Health and Mental Hygiene

				Certific	ate of	Death	R	eg. No.	UU		,
Dhysisian	1. Decedent's Neme (First, Middle, La						2. Date of Dee	th	Уеац	3. Time of I	
Physician /Medical	William	Grant, J	Jr.				MARCH	14	Ĭ999	2:30	A.M
Examiner	4a Facility Name (If not institution, giv					4b. City, Town, or L	ocation of Death	4c. County			
	Mercy Hospit 5. Sociel Security Number 6. S				ospic nder 1 Yeer		timore 8. Date of Birth	NA		/01-1-	Feeder
eral ctor	250-36-4750 X	² M 2□ F 71	(In yrs. last bi	Yrs. Mont		Hours Min.	(Month, Dey	Yeer)	9. Birthpie Counti SC	ace (Stete or ry)	roreign
	Usual Residenca of Decedent 10a. State 10b. County		10c. City, Tow	vn or Location					10	d. inside City	/ Limits
To Be Completed by Funeral Director	MD NA		Balt	imore						1 Yes	2 □ No
Director	10e. Street and Number			10f.	Zip Code		1	0g. Citizen of V	Vhat Count		
	1520 Holbrook	Street			2120	12					
Funeral	11. Marital Stetus	12. Was Decedent Ev	ver in U,S.	13. Was De		dispanic Origin? (Sp an, Mexican, Puerto	pecity Yes or No-		a - America		
by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💆 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			specify Cubi		Hican, etc.)	Specify	k, White, e		
ted	15. Decedent's Ed	Jucation	168	. Decedent's L	Isuai Occup	pation	ele e	16b. Kind of Bu	isiness/Indi	ustry	
Completed	(Specify only highest green Elementary/Secondary (0-12)	College (1-4or 5+))	life. DO NO	T use retired	during most of worl d)	ang				
Con	Unknown	NA		Unknow	n			Unknov	vn		
Be (17. Father's Name (First, Middle, Lest)					18. Mother's Nam	e (First, Middle,				
70	William Gran	nt, Sr.				Katie		Ch:	ina		
	19a Informant's Name/Relationship (Carrie Robinso	** *				own Roa					7
	20a. Method of Disposition		20b. Placa o	of Disposition (Neme of or other ple	ce)	Date	20c. Location -	City or Tov	vn, State	
	1 Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specif			hhill			em. 03-	19-99	Remb	pert,	SC
	21. Signature of Funeral Service Licer	1500	-	22. Name	e and Addre	ess of Facility B	altimor	e, Mary	/land	2120	02
	Mun (// /	0	WM C	Mar	ch FH 1					
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do							Approximate	
	snock, or heart failure. List only	on each line								Interval Betw Onset and D	
	Immediate Cause (Final disease or condition	Makes	1 /1	2	IMA	Cana	20		17	inkn	NIM
	resulting in death)	a. // UCCOS	ue to (or as a	consequenca	of):	Corro	- (- 14	naon	0001
ne				, , , , , , , , , , , , , , , , , , , ,							
Examiner	Sequentially list conditions.	b	ue to (or es e	consequence	of):						
	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying										
edical	Cause (Disease or Injury that initiated events resulting in death) Last	C. Di	ue to (or as e	consequence	of):				-		
Med	resulting in death) cast								1		
an/		d							1		
Physician/	Part II. Other significant conditions of	ontributing to death but	not resulting	in the underlying	ng cause giv	ven in Part I.	23b. Did to	obacco use co	ntribute to	the cause o	f death?
Ph.							1 🗆 Y	es 2 No	3 Prob	ably 4⊡l	Jnknown
by									1		
Completed							24a. Was a perfor		eve	re autopsy fii ilable prior to	
ple										npletion of ca leath?	luse
Con							1 🗆 Y	es 2 No	1 🗆	Yes 201	No
0	25. Was case reterred to medical					28. Place of Dea	th (Check only or	e) STELL	A MAR	IS AT	MERC:
To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/O	utpatient 3	DOA Ott	ner: 4 Nursing H	ome 5 Resid	enca 6 XIOth	er (Specify	HOSE	PICE
	27. Manner of Death	28a. Date of Injury (Month, Dey		Time of injury	28c. Injui	ry at	28d. Describe h	ow injury occur	red		
atio	1 Natural 5 Pending 2 Accident Investigation	1	,	М		Yes 2□No					
tific	3 Sulcide 6 Could not b	28e. Placa of Injury building, etc.	y - At home, f	arm, street, fac	ctory, office		28f. Location (S City or Tow		er or Rurel	Route Numb	oer,
Certification:		Donolly, etc.	(Specify)				J., J. 10H	,			
		ysician: To the best of niner: On the besis of e									
edicai	one) 2 Medical Exam	and manner state	ed.	nwor investiga	tion, in my c	philiphi, death occu	red at the time, o	are and placa,	and due to	ure cause(S)	
Σ	29b. Signature and title of certifier				29c. Licens			9d. Date signe			
	> BU IX	M			1	40854	/	MARCH	15,	1999	
	30. Name and address of person who	completed cause of dea	ith (Item 23a)	(Type, Print)		01 0	Altim	- 0 -	MIN		
	DAVID RISER	ER9 3	30/	STPA	ul t	1 B	HITIM	DRE	III	2/2	02
State	1. Date filed (Month, Day, Year)	\$2. Registrer	s Signature	1	-						



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 8 3 0 7 Certificate of Death Reg. No. 2. Data of Death 3. Tima of Dea

-			Certifica	ate of Death		Reg. No.		301
Physician	1. Decedent's Nama (First, Middla, Las				2. Data of De Month	ath Day	Yaar	Tima of Death
Physician /Medical	LEAN (GREGG			HARC		993	4:15 A.M
Examiner	4a Fecility Name (If not institution, give			4b. City, Town, or		4c. County	of Death	
	ST AGNAS H	POSPITAL			MONE	/	JA	
uneral rector	5. Social Security Number 6. S 215-05-1760 1 Usual Rasidance of Dacedant	ax 7. Aga (In yrs.	80 Yrs. Month	dar 1 Year If Undar 24 Hrs ns Days Hours Min		y, Year) 9, 1918	9. Birthplace Country)	(State or Foreign
* w	10a. State 10b. County	10c. Cit	ty, Town or Location				10d. lr	nsida City Limits
to fee	MT NA		BA	TIMORE (TIV		1	Tas 2 No
be notified	10e. Street and Number			Zip Coda		10g. Citizan of \	What Country?	
	909 EASTE	RN AJE	2010	2/202	-	1	150	
Funeral	11. Marital Status	12. Was Decedent Ever in U	J,S. 13. Was De	cedent of Hispenic Origin? (Specify Cuban, Maxicen, Puar	1	- 14. Rac	e - American In	dian,
Fu F	1 Never Married 2 Married	Armed Forcas?		1.	to Hican, atc.)		ck, Whita, atc.	
by	3 Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas:	1 U Yas	2 No Specify:		Specify	WHIT	E
Completed	15. Decedant's Ed	ducation	16a. Decedent's U	sual Occupation	rkina	16b. Kind of B	usinass/industr	/
d e	(Specify only highast gra	College (1-4or 5+)	lifa. DO NO	work dona during most of wo T usa ratired)	nking			
5	12	MA	Hom	Enaker		OWA	Hom	E
Be	17. Father's Name (First, Middle, Last)				ma (First, Middla,		na)	
10	SAM GOLT	STEIN		Softie	Col	RY		
-	19a. Informent's Nama/Ralationship (Type, Print)	19b. Mailing Addr	ass (Straet and Number or R			Stata, Zip Cod	a <i>)</i>
M. U.S.	DRUCE GREGO	a (SON)	1511	RAWHINDS	Well	RD.	Bosto	21228 71%
Olio	20a. Mathod of Disposition	20b. I	Place of Disposition (I	Nama of Or other piece)	Pata		City or Town,	
5	1 Burial 2 Cramation 3 ☐ 4 Donation 5 ☐ Other (Specification)	Removal from Stata	DAVLAN	1) CENTERN	719/19	RIT	nd.	
Ciniu a	21. Signature of Funeral Sarvice Licen	Noe /	22. Name	and Addrass of Facility LA NOCE Z S-HIGH	10.110	51200	pache	ME
any poo	TA	10 11	DEL	LA NOCE &	-2012	170 7	12027	ud.
	() LAP	self gar	¥ 32	2 S. HIGH	51-01		400	roximata
	shock, or must failura. List only	ona cause on each line.	in. Do not enter the n	loda of dying, such as cardia	ic or raspiratory a	rasi,	Inta	rval Batween sat end Death
ian ical	Immediata Ceusa (Final		- * **					
ner	diseasa or condition resulting in deeth)	. HYOCAR	NIAL IN	-ARCHION			ł	PAG
- To		,	or es e consequance	of):				
듵		b. SEPSI	\$					PAY
Examiner	Sequentially list conditions, if any, laading to immadiate ceusa. Enter Underlying Causa (Disaasa or injury		or as a consaquanca	of):			į	
	ceusa. Entar Undarlying Causa (Disaasa or injury	c. Renocl	FMILUR				3	4 EARS
edical Examir	thet initiated evants rasulting in daath) Last	,	or as e consequance o					
		9 HABENL	BNL'ON	1			12	YEHRS
clan								
y Physic	Part II. Other significant conditions of	ontributing to death but not ras	sulting In the underlyIn	g ceusa givan in Part I.				cause of death?
Ph	Divient i cul	1717.			1 🗆	Yes 2□No	3 Probably	4 Unknown
d by P							T 0.45 141	Manage Marks
page 2 should be detached for use a Completed by Physician/M						an autopsy rmed?	availabl	utopsy findings le prior to tion of causa
rector, page 2 should					3.61		of daath	tion of ceusa n?
Com					10	Yas 20 No	1 🗆 Yas	2 No
Be (25. Was case referred to medical axaminar?				ath (Check only	one)		
j 0	1 Yas 2 No	Hospital: 1 Minpatient 2 □	ER/Outpatient 3□	DOA Othar: 4 Nursing	Homa 5 ☐ Resi	dance 6 Oth	nar (Specify)	
nera	27. Menner of Deeth 1 Natural 5 ☐ Pending	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe	how Injury occur	red	
atic	2 Accidant investigation		M	1 Yas 2 No	100			
Iffic	3 ☐ Suicida 6 ☐ Could not be determined	28e. Place of Injury - At h building, atc. (Special	oma, farm, straat, fac	tory, office	28f. Location (City or To	Street and Numb	ber or Rural Rou	uta Number,
completely filled in by the funeral Medical Certification: 1		Junuing, atc. (Specia	.,,		0.1, 0.7,01	,,		
al		ysician: To the best of my kno						
completely filled in by the	(Check only 2 Medicat Exam	niner: On the basis of axamine and manner stated.	ation and/or invastiget	ion, in my opinion, death occ	urred at tha tima,	data and place,	and dua to tha	ceusa(s)
Me	29b. Signatura end titla of certifiar			29c. Licansa number		29d. Date signe	d (Month, Day,	Year)
=	> lul 1	M	The Park	512597		MAR	16 19	98
	30. Nama and addrass of person while	completed cause of death fiter	m 23a) (Tuna Drint)	1 3 12				
		KAWA CEC	90.5	CATON AVI	2, 1341	TIMON	F , 141) .
	MAICSYMILL'AN 31. Data filed (Month, Day, Year)	32. Ragistrar's Signa		GFT A	1 12110	, , , , - , ,	- (. (.	
State	MAD 1 m	1000 Nagistrali s Signi	13	1				



99-1493-510

THOMAS GALANTINO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death	Reg. No.	000	
State of Maryland / Department of Health and Menta	al Hygiene	083	0.8
	9		

Physician	
' /Medical	
Examiner	

3. Time of Death 4:54P.M.

10d. Inside City Limits

Approximete tnterval Batween Onset end Deeth

1 Yes 2 No

Funeral Director

the Marylend

7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

Director 2 should be filed within 72 hours efter death send Mental Hygiene. Is marked other than "naturel", or items 23. Funeral Baltimore, Maryland 21215-0020 þ Completed Be 10 permit. Pages 1 and 2 sl Department of Health enc Important: If Nem 27 Ie n Injury or **Physician** /Medical **Examiner** Examiner attending physician end for use as the burial-transit Records, P.O. Box 68760. Physician/Medical signed by the a à Completed peen page 2 hes Division of Vital director, Be Certification: To this uneral death. ofter death Director: To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the Medical

1. Decedent's Neme (First, Middle, Last) 2. Data of Daeth Month 13, 1999 MARCH HOMAS 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Nama (If not institution, give street end number) N/A JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year | If Undar 24 Hrs. 5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country). 8. Data of Birth (Month, Day, Year) Months Deys Hours 14 M 2□ F 213-28-6047 Yrs. APRIL 9,1931 Usuel Residence of Decadent 10a Stete 10b. County 10c. City, Town or Location NIA MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ALLEY 21202 USA ALLEN 1007 14. Rece - Amarican Indien. 11. Meritai Stetus 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 1 ☐ Never Merried 2 ☐ Merried 1□ Yes 20 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) IMPORT-EXPORT Elementery/Secondery (0-12) College, (1-4or 5+) SHIPYARD JA STEUADOR 10 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) ANGELO ALICE NARDO GALANTINO 19b. Meiling Address (Street end Number or Rurel Route Number, City of Town, Stete, Zip Code) 19e. Informent's Name/Relettonship (Type, Print), Loseph GALANTING Rethon existral/ 2/128 Hd: OX 20b. Plece of Disposition (Neme of cametery, cremetory or other p Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Servica Licansee 22. Name end Address of Fecility FUNCKAL SONS OLE DELLA N UTO 2/202 322 S. Hild Puril. Enter the disease, or complications that causad the daath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in deeth) ease Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequence of) Due to (or es a consequance of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes an eutopsy 2□No Tes 2 No 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

29a. Certifier (Check only one)

29b. Signature end title of cartifier 29c. License number

1 Cretifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Madical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. 29d. Dete signed (Month, Day, Year)

O.C.M.E.

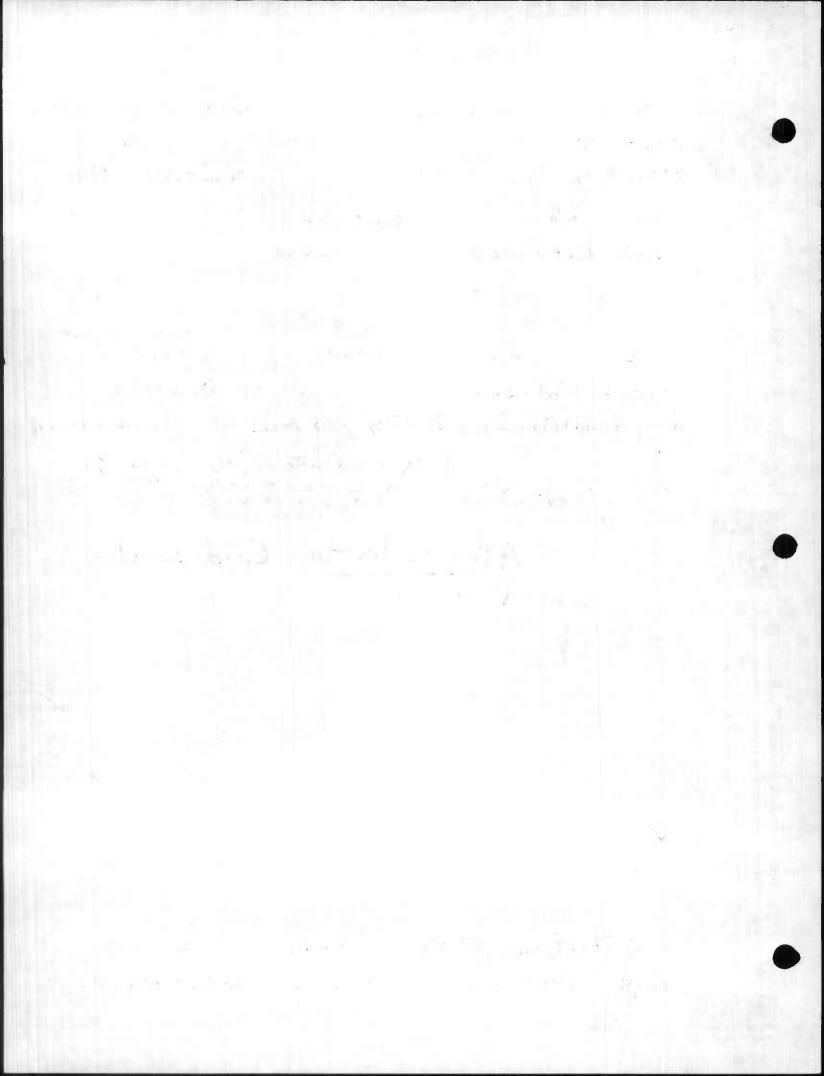
MARCH 14,1999

30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print)

oseph 31. Deta filed Month, Day, 111 Penn Street, Baltimore, Maryland 21201

State Registrar





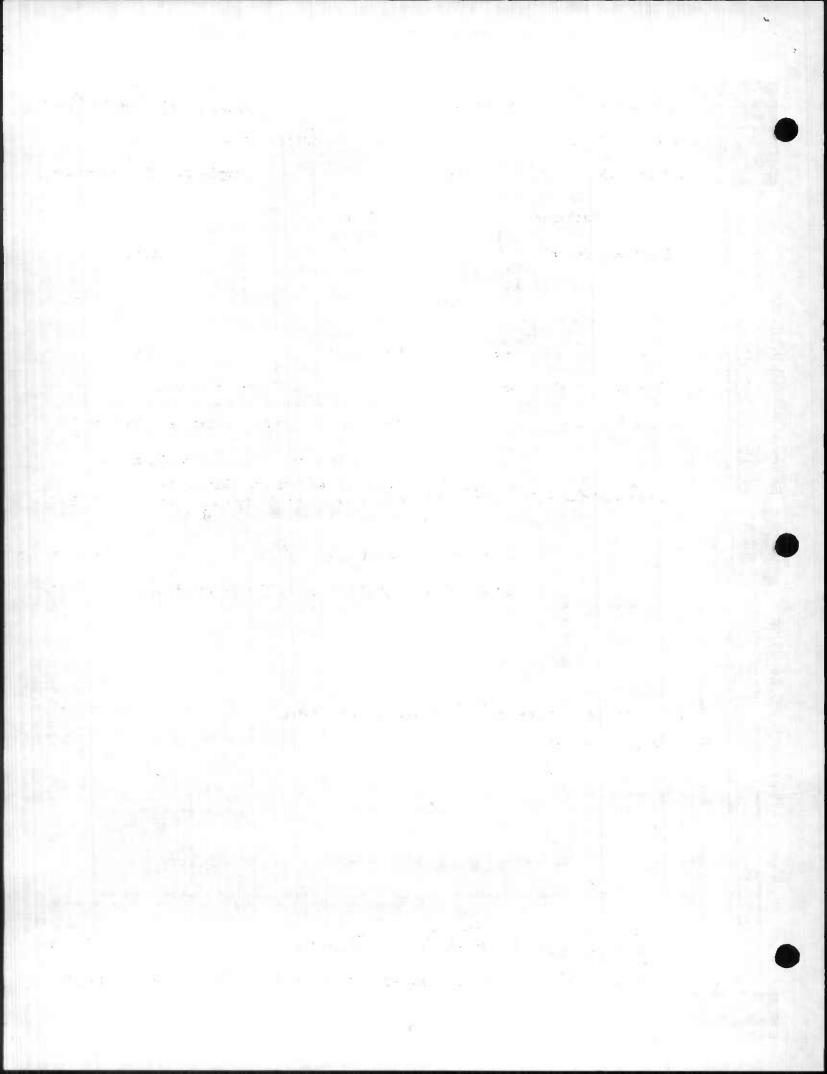
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Benjamin Goode
4a Fagility Name (If not Institution, give street and number) **Physician** GOODEN 0420 March /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ma If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 10XM 2□ F Yrs. 212-09-0215 88 **Director** Sept. 17, 1910 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show treumstic event, the Mexical Examiner must be recitied at 1 Yes 2 XNo MD Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Crismer Court 21207 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 125 Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter Department of Helelin and Mental Hygiene. Important: if item 27 is marked other than "natural", or he any injury or other traumout. 1 □ Never Married 2 □ Married Maryland 21215-0020 1 Yes 2 XNo Specify: þ White 3 XWidowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) -0-Accountant Exxon 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Benjamin Franklin Gooden, Sr. Elizabeth Freeman 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Eileen Dix 1304 Green Pon Court Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Dete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery Mar 17, Woodlawn, MD 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee USINS 8728 Liberty Road Randallstown, MD 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical Sudden cardiar 30 minutes **Examiner** Due to (or as a consequence of): Examiner 5 Years CORONARY ARTERY DISEASE physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) esn Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown episode of Gastro Intestinal g 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? bleedino hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation al or Attenuars effector: A refilled in by the 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital 24 hours e Funeral D 29a. Certifier Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) To the To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatury and title of certifier 129391 14, 1999 MARCH Victor yamin 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Pikesville, MARYLAND 21208 foad 1838 Oreene 1100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAR 1 7 1999

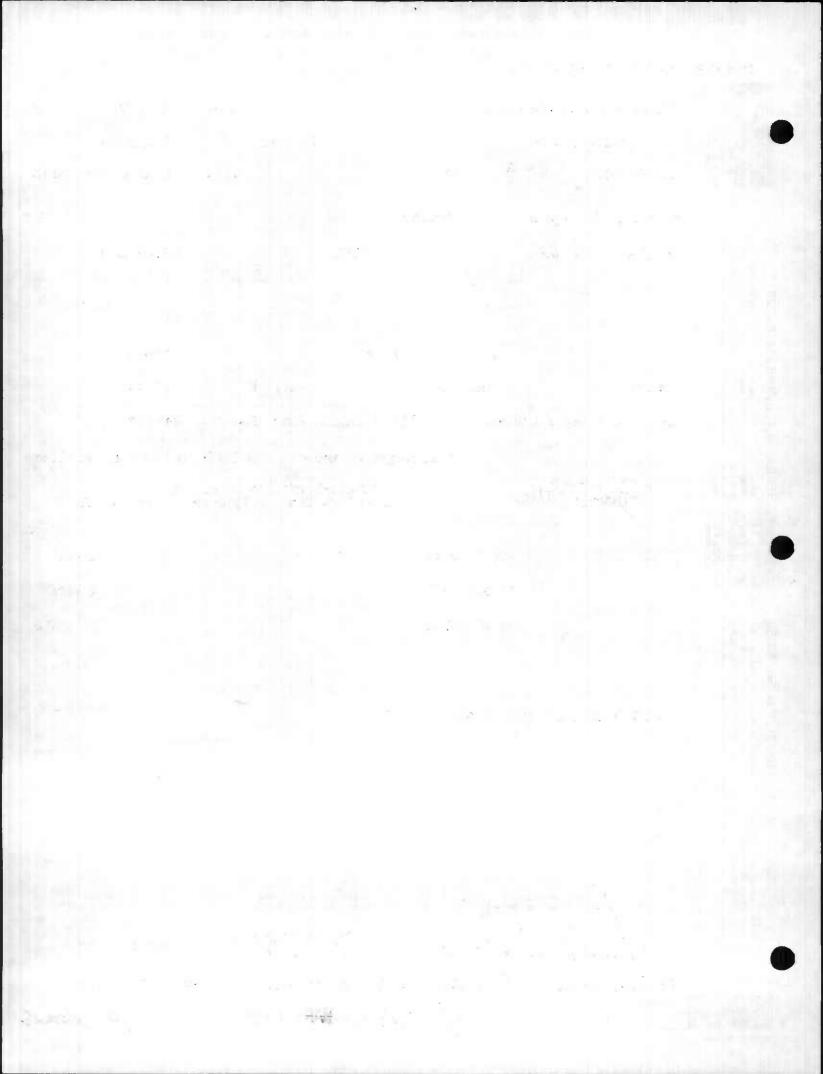


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State of Maryland / Department of Health and Mental Hygiene

Item	31 Pe	r DVR Film G769 3-17-9	9 rja		Cer	tificate (of L	Death			Reg. No.		0010	
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th the	Director	10e. Street and Number				10f. Zip Co					10g. Citizen of		*	
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		23a. Part1. Enter the disease, or cor shock, or heert failure. List only	nplications that cau	used the death.		500 You		g, such as car	rdiac or re	espiratory	arrest,	LCITAL	Approximate Interval Between	
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To th To th	Me duos	29b. Signature and title of cartifier				29c. Li	icense	number	/ =	,	29d. Data sign			
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	9	30. Name and address of person who	completed clause	of death (Item 3	e) (Type,	Print)			_					
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month MARCH 11-1999 SADIE E. HOWARD 7:00 A.M 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth 6036 BALTIMORE ST. (HOME CARE) BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) 1 □ M 2 ☑ F Months Days 216-12-8321 Usual Residence of Decedent N.C 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2334 W. MOSHER ST. 21216 U.S.A. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: SpecifyAFRO-AMERICAN 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 DOMESTIC WORKER HOUSEHOLD 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) JOSEPH BULLOCK SADIE BULLOCK 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 2334 W. MOSHER ST. BALTIMORE MD. 21216 CARRIE BRIGHT (SISTER) 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crametory or other place) 20c. Location - City or Town, State **VOXBurial** 2 ☐ Cremetion 3 ☐ Removel from Stete MARYLAND NATIONAL MEM PK.3/16/99 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 21 Signature of Funeral Service Licenses 1300 EUTAW PLACE BALTIMORE MD. 21217 23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Ceuse (Final diseese or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? 45 1 Yes 2 No 3 Probably Onknown 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Wes en eutopsy performed? 20 No 1 Yes 1 Yes 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

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7 is marked other than "naturel", or itema 23a or 28a-f show traumstic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after on and Mental Hygiena.

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m any Injury or other traum

Baltimore, Maryland 21215-0020

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and physician 2 å signed by t Deen page 2 certificate 2 or Attend after death Director:

Division of Vital Attending Physician: Physician/Medicai by Completed Be 2 Certification:

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29b. Signature end title of certifie

pleted cause of deeth (Item 23) 0 Registrer's Signature

State Registrar Part I Other significant conditions contributing to death our not esulting in the underlying ceuse given in Pert I. 25. Was cese referred to medical examiner 1 ☐ Yes 28e. Date of Injury (Month, Dey Year) 27 Manne of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

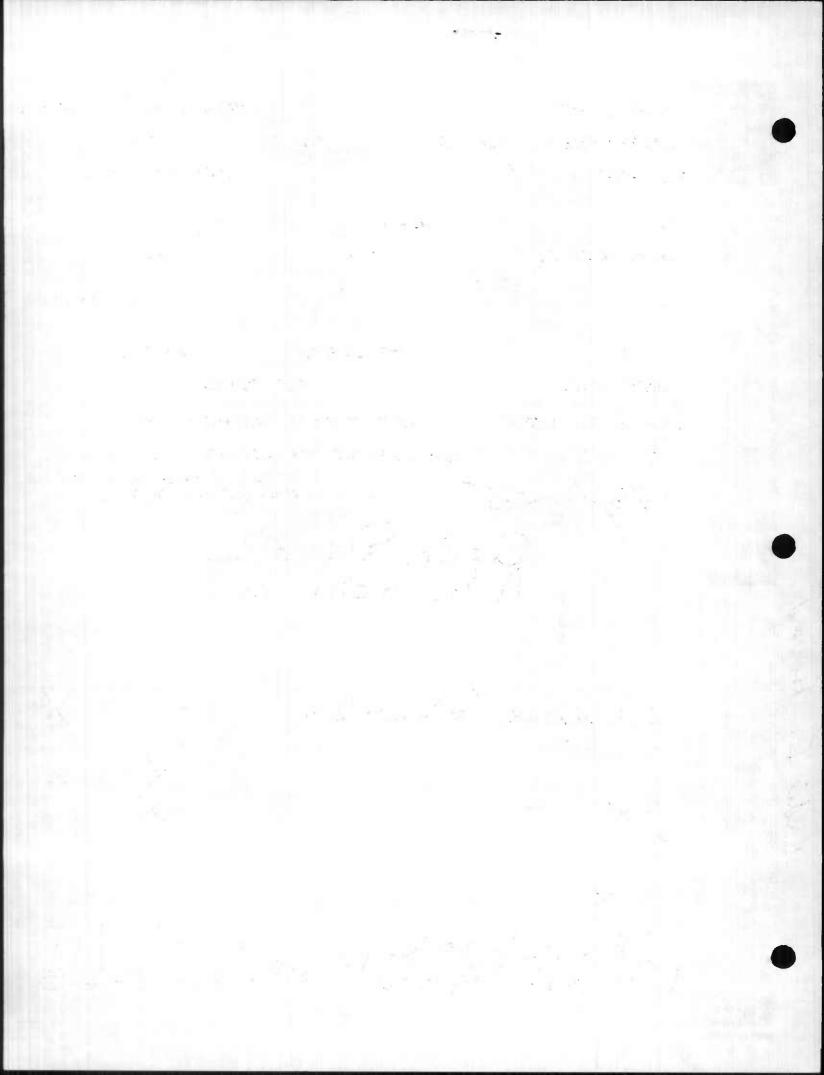
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Dey, Year)

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) CARMEN ELIZABETH MARY HAWKIN March 3 1999 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, giva street and number) Moryland Birthplaca (Stata or Foraign Daltimore Age (In vrs. last birthday) If Undar 1 Yea mano 5. Social Sacurity Number Age (In yrs. last birthday) 1 M 2 XF Months Days NEW YORK, CITY 098-32-8279 Usual Rasidance of Dacedent 10a Stata 10b County 10c. City. Town or Location 10d. instda City Limits V☐ Yas 2☐ No MARYLAND CATONSVILLE 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 21228 USA 2 DUNBAR AVENUE 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: 14. Race - Amaricen Indian, Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexicen, Puarto Rican, atc.) Black, Whita, atc. 1 Nevar Merried 2 Married 1□ Yas 2□ No Specify: Specify: AFRO. AMERICAN ¾(☐) Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondery (0-12) College (1-4or 5+) 4 COMMERICAL ARTIST AVON COSETICS 18 Mother's Name (First Middle Meiden Sumema) 17. Father's Name (First, Middle, Last) **GEORGE** FLEMING LUELLA FLEMING 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) DAUGHTER 2 DUNBAR AVENUE, CATONSVILLE, MARYLAND 21228 NINA CARDENAS 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 3/20/99 CATONSVILLE, MD. METRO CREMATORY 22. Name and Address of Facility ESTEP BROTHERS FUNERAL SER, P.A. 21. Signatura of Funarat Sarvice Licensaa LLOYD M. ESTEP 23a. Part I. Entantha Jisease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. EUTAW PLACE, BALTIMORE, MARYLAND 21217 Approximata Intervat Batwaan Onsat end Daath immediata Causa (Final disaase or condition resulting in daath) Sequantiatly list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceusa (Diseasa or Injury that initiated avants rasulting to daath) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contributa to the causa of death? 2 No 3 Probably 4 Unknown 1 Yes (MM400 DRICIBNCY VIRUS 24b. Were autopsy findings availabla prior to completion of ceuse of deeth? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 ☐ Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accidant 5 ☐ Panding 1 Yes 2 No invastigation

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25. Was cesa raferred to medicat axaminar?

29a. Cartifiar (Check only one)

3 Suicide

4 ☐ Homicida

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certifiar

MAR 1 7

29c. Licensa number

29d. Data signad (Month, Day, Year)

Atturbuy Doctor

6 Could not be datermined

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3.13.1999

28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print)

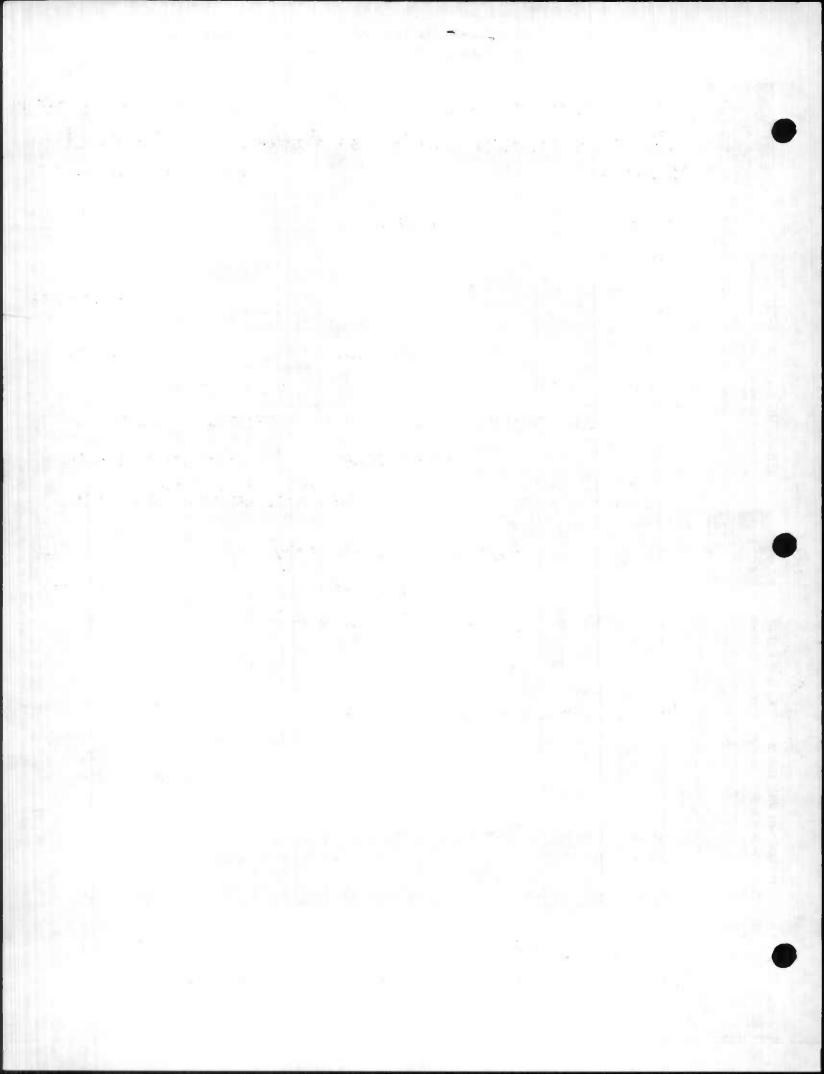
CYRIAC- M.O 8109 RITCHIB HWY

DASAOBNA MD 81122

State Registrar

32. Registrar's Signatura

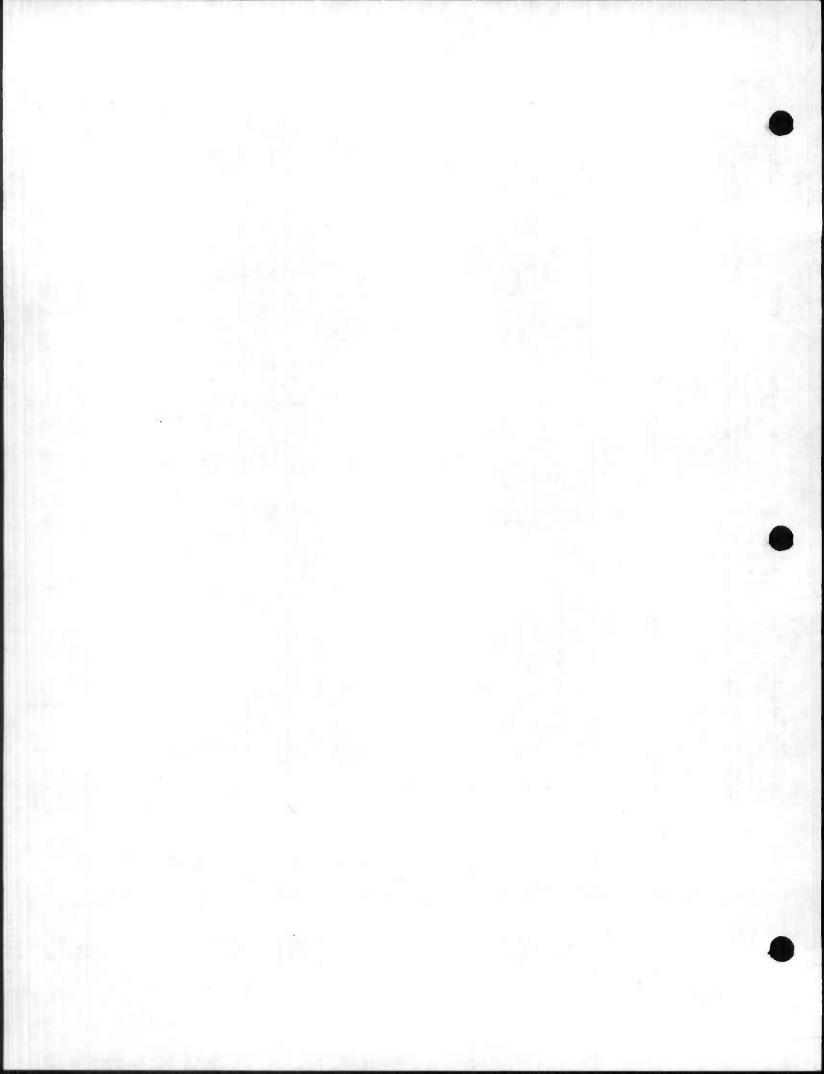
28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)



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State of Manyland / Department of Health and Mental Hygieng

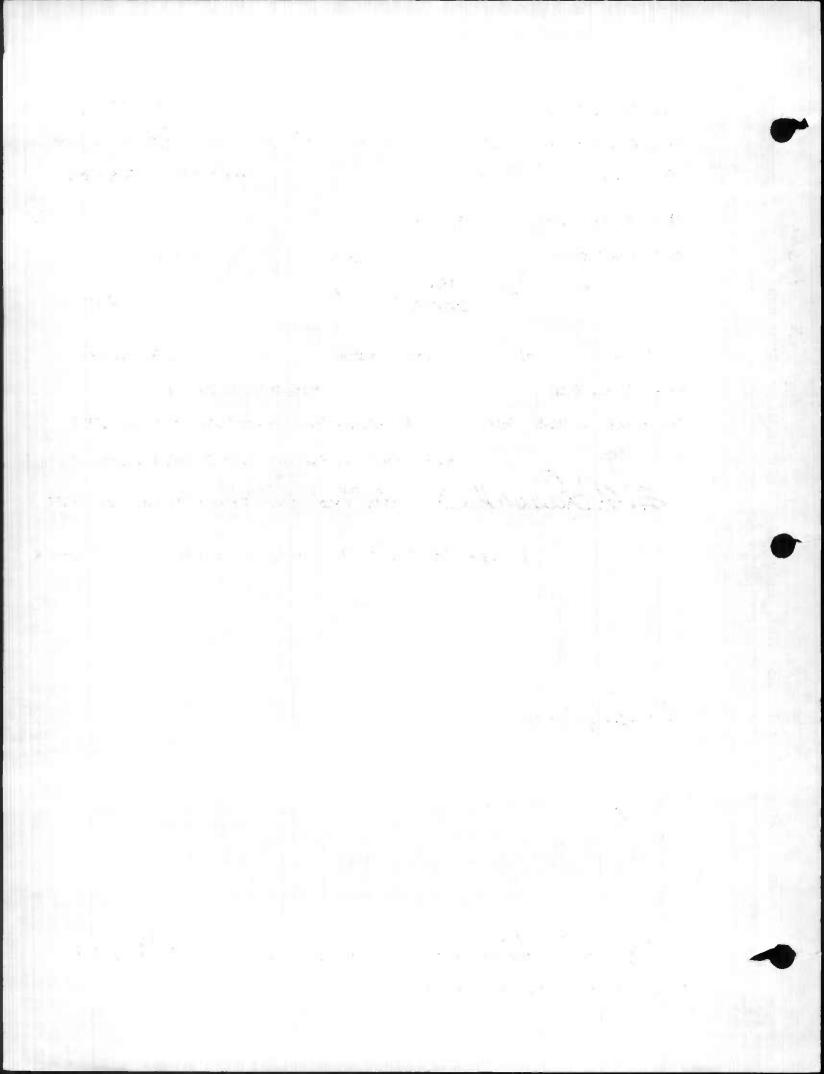
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2 should and Men is marke sumatic	19s. Informant's Name/Raiationship (vpe. Print)	19b. Maili	na Address (Stree	nt and Number or R	ural Route Numbe	or, City or Town,	State, Zip C	ode)
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Cificate be executed and physician and physician and set the bunal-transit examiner.	Immediata Causa (Finel disaasa or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underfying Cause (Disease or injury that initiated avants resulting in death) Last	b. Ma	ua to (or as a consecutive of the consecutive of th	quance of):	eden	100			nset and Death
attending for use a		d							
es that the death certigned by the attending be detached for use a by Physician/M	Part II. Other significant conditions co	entributing to death but	not rasulting in tha u	indarlying cause g	iven in Pert I.			3 Probe	he cause of death bly 40x Unknow
been sign should be		- 1				24a. Was perio	an autopsy med?	availe	autopsy findings able prior to detion of cause ath?
The law ate has page 2						101	as 2 No	101	ras 2□ No
certificate rector, pag	25. Wss casa rafarrad to medical				26. Placa of De	ath (Check only o	na)		
Physician: rthis certific and director, ral director,	axaminar?	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA O	ther: 4 Nursing I	loma 5 ☐ Rasio	lence 8 Othe	or (Specify)	
er thi	27. Manner of Death	28a. Data of Injury (Month, Day)	28b. Tima o			1	now injury occurr		
Attending P or death. ector: After by the funer Ification:	1 Selection 1 Selection 1 Selection 5 Pending 1 Pending			M 1[Yas 2□No				
tal or Attending P rs after death. al Director: After t led in by the funers Certification:	4 Homicida determined	28e. Plece of Injur- building, atc.	y - At homa, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Number on, State)	er of Rufal F	louta Number,
To the Hooptal or Attending Physician 24 hours after death of the Funeral Director: After the completely filled in by the funeral Medical Certification: 7	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the besis of e and manner state	xaminetion and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, daath occu	e, and due to the urred at the time,	cause(s) and mai data and place, a	nner as stat and dua to th	ed. na cause(s)
within To the comple	29b. Signatura and tilla of certifiar	1		29c. Licer	sa number		29d. Date signed	(Month, Da	y, Year)
- 5 - 0	1716	211/195		Do	36538	- 1	2/11	199	
1	20 Name and address of access to	ompleted as a six	th (learn 22a) (Time		,,,	1	7/10		
	30. Nama and addrass of person who o					ID 00==	_		
	Laura Weber, I	M.D. 8317 32. Ragietrar	Cherry	Lane L	aurel, l	MD 2070	1		
State Registrar			s Signatura	1					



is Hash

	State of Maryland / Department of Certificate of	of Death	Reg. No.	08314
Diam'r Inc	1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month / Day	3. Time of Death
Physician /Medical	Lewis C. Hash		march 12.19	799 3:58an
xaminer	4a Fecility Name (If not institution, give street end number)	4b. City, Town, or Locati	ion of Deeth 4c. County	of Death
	Franklin Square Hospital Center	Rosedo	ale Ba	1timore
eral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
or	227-16-1496 1XM 2 F 79 Yrs. Months Da			Fox, Virginia
	Usual Residence of Decedent			
	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Director	Maryland Baltimore Perry Hall			1 ☐ Yes 2 No
5	10e. Street and Number 10f. Zip Cod	le	10g. Citizen of V	What Country?
	4309 Chapel Road 21128	3	U.S.A.	
Funeral	11. Mantal Status 12. Wes Decedent Ever in U,S. 13. Was Decedent	of Hispenic Origin? (Specify Cuban, Mexicen, Puerto Rice		e - Americen Indian,
	1 Never Married 2 Married 1 Mayes 2 No ADITI			ck, White, etc.
2	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1941–1945	No Specify:	Specify	White
Completed	15. Decedent's Education 18a. Decedent's Usual Oc	ccupation one during most of working	16b. Kind of Be	usiness/Industry
ple	(Specify only highest grede completed) (Give kind of work do life. DO NOT use rel Elementery/Secondery (0-12) College (1-4or 5+)	tired)		
0	7 yrs. n/a Warehouseman		U.S.Gov	ernment
Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Malden Surnen	
	Robert Louis Hash	Buelah Clyd	de Phinos	
			oute Number, City or Town,	Stete, Zip Code)
	Mrs. Lenore V. Hash (Wife) 4309 Chapel	Road Perry	Hall, Maryla	nd 21128
	20a Method of Disposition 20b. Place of Disposition (Name of	1		City or Town, State
	1 M Buriel 2 Cremation 3 Removal from State		15/00 DalAin	M 01014
	4 □ Donation 5 □ Other (Specify) BelAir Memorial 21. Signature of Funeral Serfice Lumber 22. Name and Ad		13/99 BETAIL,	Maryland 21014
		ahn Funeral H	Home	
	5 7 () () () 11750 Be	lair Road Ka	ingsville.Mar	yland 21087
	23a. Pert1. Enter the disease of complications that caused the deeth. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac or re	espiretory arrest,	Approximete Interval Between Onset and Deeth
lner	Immediate Cause (Final disease or condition resulting in death) e. Interstitial Purple to (or es e consequence of):	1 monary	Fibrosi	s 5 years
Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.			
Ilcai	Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of):			
by Physician/Medi				
an/	0.			1
SICI	Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse	given in Part I.	23b. Did tobacco use co	ntributa to the causa of death?
Å,	Fmal		1 Nas 2 No	3 Probably 4 Unknown
by	Emphysema			
Completed	,		24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to
ole C			,	completion of cause of deeth?
			1□ Yes 2 No	1 Yes 2 No
	25. Was cese referred to medical	OR Dines of Death 10		· we too a feel too
	examiner? Hospital: . /	Other:		nos (Canaibs)
	1 2 inpatient 2 DEH/Outpatient 3 DOA	4 U Nursing Home	5 ☐ Residence 6 ☐ Oth 1. Describe how Injury occur	
Certification:	Table 1 along	Injury at 28d Work? 1 ☐ Yes 2 ☐ No	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Ca	3 Suicide 6 Could not be		. Location (Street and Num.)	ber or Rurel Route Number
Ē	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)	201	City or Town, Stete)	
edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in men distance, and manner stated.	ne time, date end plece, and ny opinion, death occurred	due to the ceuse(s) and ma at the time, date and plece,	anner as steted. and due to the cause(s)
Med		cense number	29d Date slone	od (Month, Day, Year)
	250. 510		- 1	-100
	(Vamely Springers D	53694	3/1	2/79
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0		
	D. Daniel Shinners 9000 Franklin Square 1	Drive Balt	more, mD	21231
	31. Date filed (Month, Day, Year) 32. Registrer's Signature	and the same of th		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death MARCH DO LORES HOLLOWA 11:17 PM 4e. Facility Neme (If not institution, give street end number) b. City, Town, or Location of Deeth 4c. County of Deeth RANATUSTOWN NORTHWEST HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 1□M 2XF Months Deys Hours 402-32-1745 78 2-17-21 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE WOODLAWN 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 47 TRIPLE CROWN CT. 21244 USA 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ♥ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) -12-CARE PROVIDER -0-HEALTH 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) ERNEST HOLLOWAY MARGARET JOHNSON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ALTAMEASE ARNOLD (DAUGHTER) 47 TRIPLE CROWN CT. BALTIMORE, MD 21244 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 3-17-99 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) METRO. CREMATORY 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or heer fellure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Finel . ATHERO SUEROTIL CARDIOVASCULAR disease or condition resulting In deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes en eutopsy performed? 26. Piece of Deeth (Check only one) 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2DER/Outpatient 3D DOA 1 Inpatient

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. Stete

MD.

Funeral

Director

28a-f show

ò

"natural", or items 23a

the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

the Maryland

death

permit. Pages 1 and 2 should be filled within 72 hours effer a Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" with any injury or other traumatic events.

physician and s the buriel-transit USB signed by the e should b certificate hes l director, page 2 s director. this funeral Affer

Hospital or Attending Physician: The law requires that the death certificate be exacuted

death.

within 24 hours a To the Funeral C completely filled

\$

Box 68760

P.O. 1

Records,

Division of Vital

Examiner Physician/Medicai þ Completed Be Certification: To ours after death.

edlcai

25. Wes case referred to medical exeminer? 1 ☐ Yes 27. Manner of Deeth 1 Naturel

2 Accident 3 Sulcide

4 ☐ Homicide

(Check only onel

29e. Certifier

5 Pending investigation 6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of

28c. Injury et Work? 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, and due to the ceuse(s) end menner steted.

29b. Signeture end tifle of certifier

29c. License number

29d. Dete signed (Month, Dey, Year) 1999

21133

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) COURT ROAD 5401 OLD

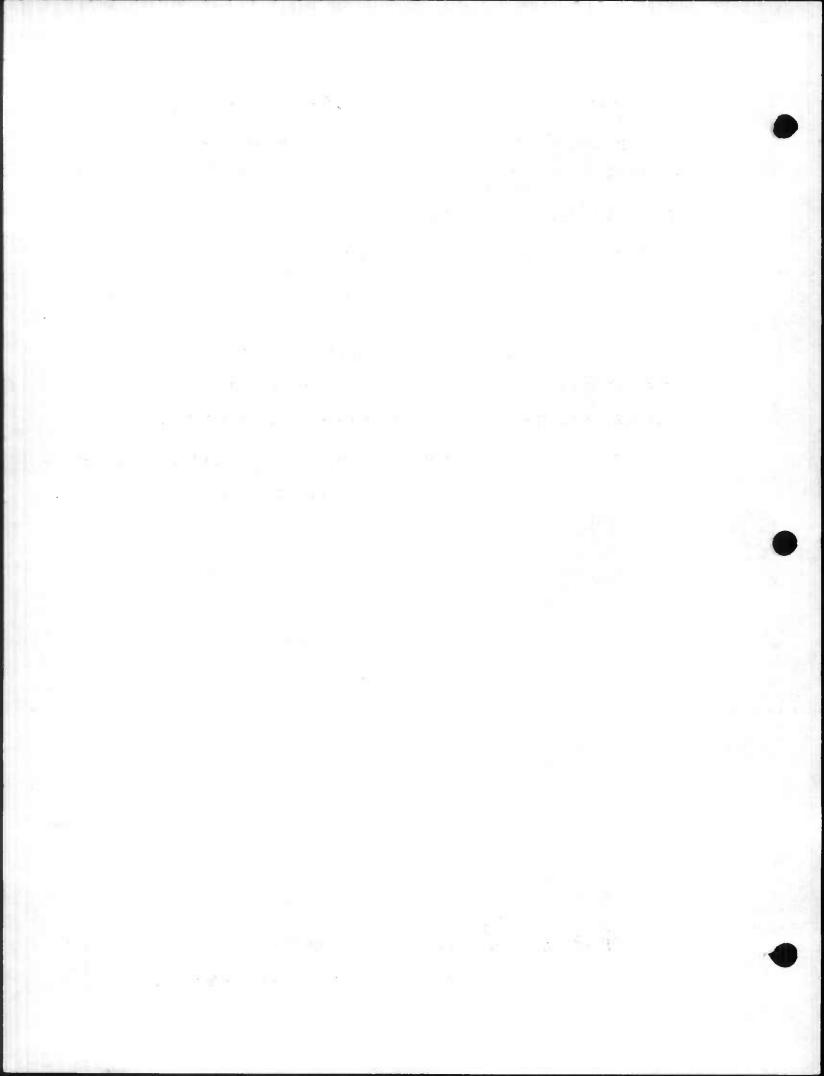
31. Dete filed (Month, Dey, Year) MAR 1

32. Registratr's Signeture 1999

RANDALL STOWN, MARYLAND

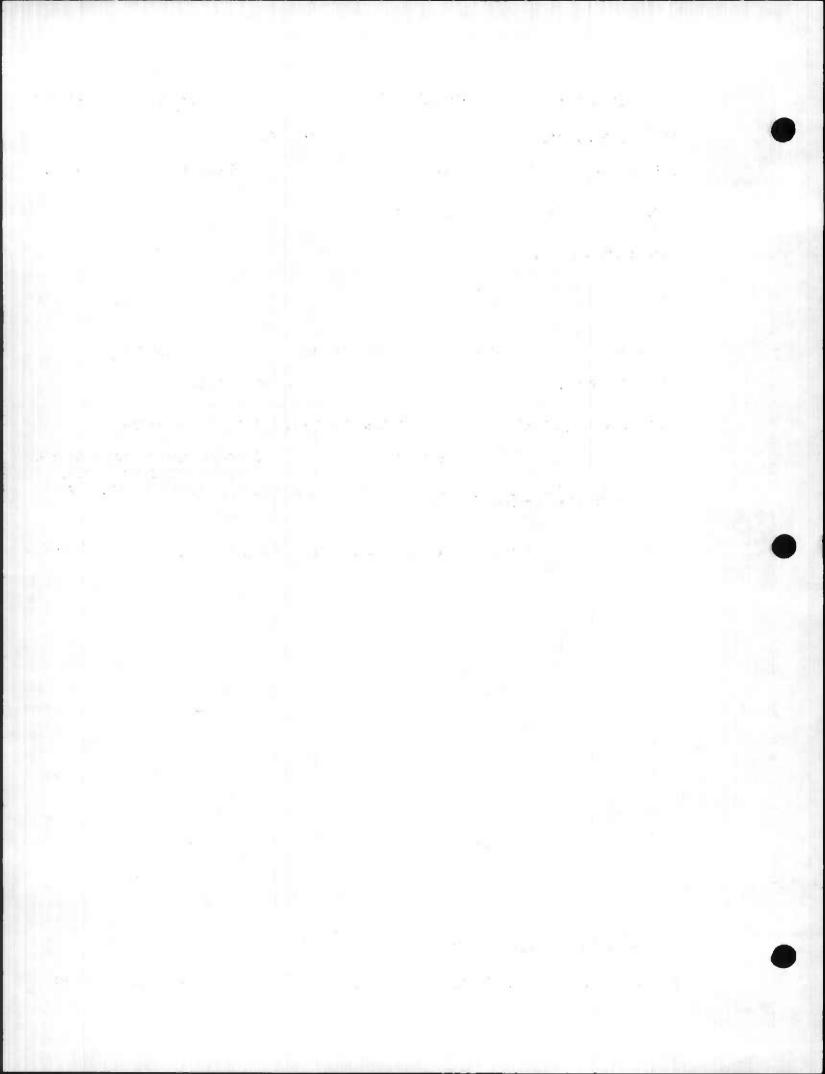
Registrar

State



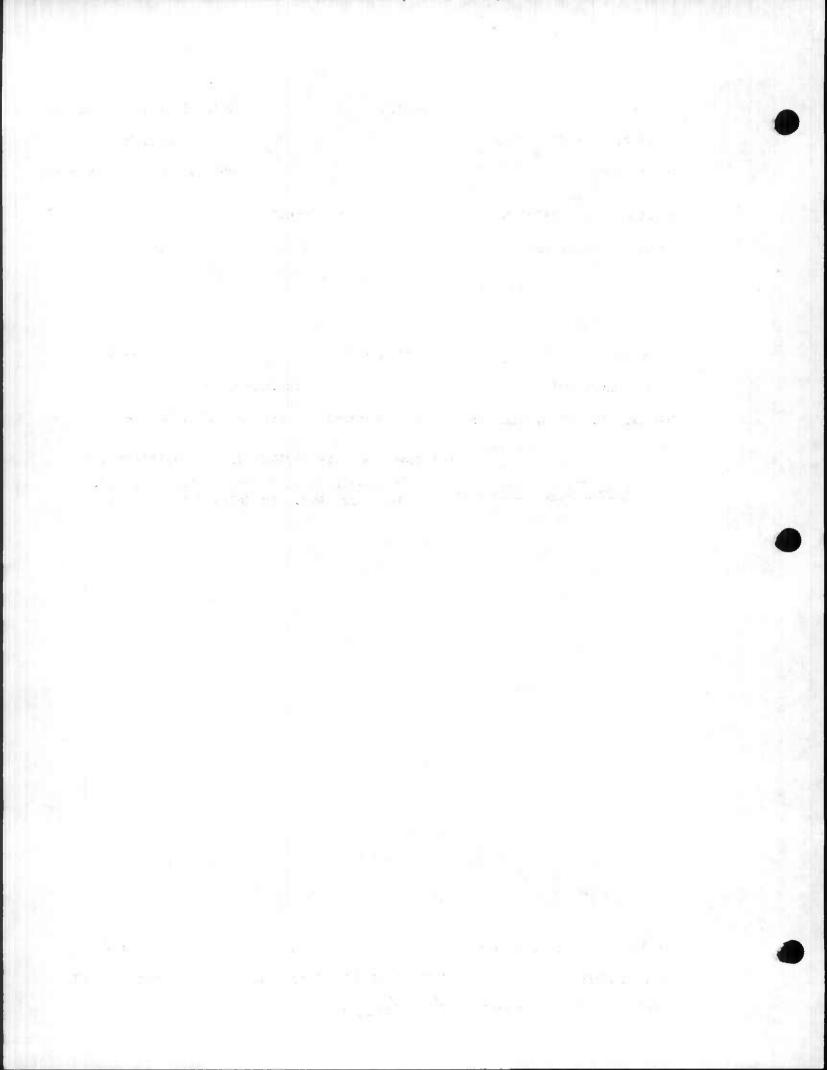
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 0 8 3 | 6

			Cen	tificate of	Death		Reg. No.						
Physician /Medica		to.	D96			2. Data of Da Month MARCH			3. Tima of Death 9:15am				
Examiner	4 - Frankling his man of the man in making the miner				4b. City, Town, of BALTIMOR	or Location of Deatl RE	4c. County N/A						
Funeral Director	247-40-1904	7. Aga (In yrs.		Months Days		in. 8. Data of Bir (Month, Da 4-26-	th 30	9. Birthplace Country)	S. C.				
death with the Maryland ms 23e or 28e-f show Email be notified at	Usual Residence of Decedant 10a. Stata 10b. County MD • N/A		y, Town or Loc LTIMORE						Insida City Limits 1 Yes 2 No				
uth with the Mar 23a or 28a-f s	10e. Streef and Number 914 ALLENDALE ST			10f. Zip Coda 2122	9		10g. Citizan of V USA	Vhat Country	?				
020 urs after ur, or its	11. Marital Status 1 Nevar Married 2 Married 3 Widowad 4 Divorcad	12. Was Decedent Evar In U Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva A Yaar or Datas:		/as Decedani of Yes, specify Cul □ Yas 2 No		(Specify Yes or No arto Rican, etc.)	Blac	a - Amarican ck, Whita, atc.					
72 hours	15. Decadant's Ed (Spacify only highest gra		(Giva k	ent's Usuel Occu	during most of v	vorking	16b. Kind of Bu	sinass/Indus	try				
1 21215-0 ed within 72 ho ygjene. Per than "natura nt, the Medical	Elementery/Secondary (0-12)	College (1-4or 5+) -0-	lifa. D	NE OPERA	9d)		PAINT	TNC					
d 2		-0-	LTI	VE OPERA	1	leme (First, Middle							
Maryland 212: d 2 should be filed within th and Mental Hygiena. T is marked other than traumatic event, the Ma	ENGGE HODGE GD					NE MONTGO							
laryla 2 should la and Meni is marked	19a. Informant's Name/Ralationship (7	Type, Print)	19b. Mailine	Address (Stree	at and Number or	Rural Routa Numb	er, City or Town,	State, Zip Co	oda)				
M 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	BRIDGET HODGE(DAU					ALTIMORE.							
of He item	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐	20b. F	Placa of Dispos	ition (Nama of atory or other pl		Data	20c. Location -	City or Town					
Pag ment ant: f ury o	4 Donation 5 Other (Specify		DON PAR			3-19-99	BALTIMO						
Baltimore, pemit. Pages 1 a Department of the important: if hem any injury or othe page.	21. Signatura of Funaral Sarvice Licen	ector CFS				HILLIPS F DE ST. BA							
	23a. Part1. Entar tha diseasa, or comp shock, or heart failura. List only	olications that caused the daar	th. Do not anta	r the mode of dy	ring, such as card	liac or raspiratory e	rrest,	int	pproximata terval Between				
Physician //wedical	Immadlate Ceuse (Final	SMALL (ELL	LUN	6 (1	1A) (F73		9	Y EARS				
Examiner	Immadiate Ceuse (Final disease or condition rasulting in death) SMALL CELL LUNG CAN CETZ. Due to (or as a consequence of):												
axecuted n and ial-transit		b	W										
58760, icate be axecuted physician and sthe burial-transit		C	or as a consequ	Jance orj.									
The same	rasulting in death) Last	Due to (c	or as a consequ	ienca of):				1					
death cert death cert e attendin ed for use						1		1					
O. the de sched	Part II. Other significant conditions co	ontributing to death but not ras	uiting In tha un	darlying cause g	iven in Pert I.		tobacco use con		ne cause of death? bly 4 ☐ Unknow				
S, P							2010	3	ny 4 dinimon				
The law requires that the death care has been signed by the attending page 2 should be detached for use						24a. Was	an autopsy ormed?	availa	autopsy findings able prior to plation of cause ath?				
of Vital Rec systelan: The law his certificate has to director, page 2 s						10	Yas 2 No	1 🗆 Y	as 200 No				
Of Vital Physician: T					26. Place of I	Death (Check only	ona)						
Of Vita Physician: this certific ral director,	1 Yas 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA O	thar: 4 D Nursin	g Homa 5 Aasi	idanca 6 Oth	ar (Specify)					
Ing Pl		28e. Dete of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inj W M 1[ury at ork? Yas 2 No	28d. Dascribe	how injury occur	red					
Division of the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	2 Accident invastigation 3 Suicide 6 Could not be 4 Homicida datamined						(Streat and Numb wn, State)	er or Rural R	louta Number,				
Ne Hospital n 24 hours ne Funeral pletaly filled		ysicfan: To the best of my kno liner: On the basis of examine	owledge, death ation and/or inv	occurrad at tha estigation, in my	tima, data and pla opinion, death o	ace, end due to that occurred et the time,	causa(s) and ma dete end piece,	inner es state and dua to th	ed. ne cause(s)				
To the within 2 To the comple		al ah	2	29c. Licar	2907	,	29d. Date signe	d (Month, Da	y, Year)				
	30. Nama and addrass of person who	completed cause of deeth (iter	n 23e) (Type, F	Print)	0 4)			- 21	1201				
2	KO KRYSHNAN	1, mo 821	NIE	UTAN	57 # 50	S BAL	TIMUR	E 41	120/				
State	31. Data filad (Month, Day, Year)	32. Registrar's Signa	ature /	book	41								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

						Certificate of			Reg. No.	J U	8317
Physic /Med		Decedent's Name (First, Mi MARY	ddle, Lest)		HE	RRING		2. Dete of Dea Month MARCH	Day 14,199	Year 9	3. Time of Death 10:55 pm
Exam		4e. Fecility Neme (If not institu	tion, give street e	nd num bei			4b. City, Town, or I				10.55 pm
,		RIVERVIEW N	JRSING C	ENTER			ESSEX		BALT	IMORE	
Funera, Directo		5. Social Security Number 163–40–9689	6. Sex 1 □ M 2(7. A	ge (In yrs. last bir	thday) If Under 1 Year Months Days		8. Date of Birth (Month, Der June 9	2	9. Birthpl Count	ace (State or Foreign ry) Virginia
pug *		Usual Residence of Decedent 10a. State 10b. Cour	ntv		10c. City, Towr	or Location				140	ad tarida Cib. I laria
Manyli f sho	Po	Maryland	Balti	more	100.00,710	r or Location	Dundalk			10	d. Inside City Limits 1 Yes 2 No
h with the 23a or 28a	al Director	10e. Street and Number 3528 Logany.	iew Driv	e		10f. Zip Code	21222		10g. Citizen of V United		
urs efter deal	by Funeral	11. Maritel Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorce	arried 1 If Yo	S Decedent ed Forces Yes 2 2 es, Give or Dates:	No	13. Was Decadent of If Yes, specify Cub		pecify Yes or No- o Ricen, etc.)	14. Rac Blac Specify	e - America ck, White, e	
filed within 72 hours efter death with the Maryland Hygiana. ther than "natural", or items 23a or 28a-f show mit, the Moltral Evantural must be notified as	Completed	15. Deca (Specify only hig Elementery/Secondery (0-12	ent's Education hest grade complete	eted) ege (1-4or	5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Homemaker	pation during most of wor ed)	king	16b. Kind of Bu		
be filed ttal Hygi d other	Be C	17. Fether's Name (First, Midd	le, Lest)				18. Mother's Nam	ne (First, Middle,			
should be nd Mantai marked o	To	David Liven	good				Virgin	ia Crane			
d S m		19a. Informant's Name/Relation				Mailing Address (Stree					
1 and Health em 27 I		Georgene W.	Wiles/Da	ughte		528 Loganv:				1	21222
permit. Peges 1 and 2 Department of Health Important: If item 27 is any injury or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		from State		Disposition (Name of y, cremetory or other ple awn Cemeter		Date 1999	20c. Location - Balti		
Depart Import any in		21. Signature of Funeral Servi	ce Licensee	>		22. Name and Addr Duda-Ruck 7922 Wise	Funeral :				
Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)			d the death. Do n ine.		ng, such es cerdiac	or respiratory are	rest,		Approximate Interval Between Onset and Death
certificate be axecuted rding physician and use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest	b c	- C	Due to (or as e c						
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v requi	Completed b							24a. Was a pedon	n autopsy med?	evai	e autopsy findings lable prior to pletion of cause eath?
The cate bag	So							1 □ Y	es 2DNo	1 🗆	Yes 2□ No
clan	Be	25. Was case referred to medic examiner?	-				26. Plece of Dea	th (Check only or	16)		
Phys this ral di	ation: To	1 Yes 2 No 27. Manner of Deeth 1 Natural 5 Pend 2 Accident invest		1 ☐ Inpation Dete of Injui (Month, Da	ıry 28b. Ti	me of jury 28c. Inju		ome 5 Reside			
tai or Atters as all Directo	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 200.	Place of Injudy	jury - At home, far c. (Specify)	m, street, factory, office		28f. Location (Si City or Town		er or Rural	Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After complately filled in by the fune fune.	ledicai	one) 2 Medic	and	o the best the basis o manner st	f examination and	death occurred et the ti /or Investigation, in my o	me, date and place, opinion, death occur	end due to the cred at the time, d	ause(s) and mai ate end place, a	nner as sta and due to t	ted. he cause(s)
To To Com	Σ	29b. Signature and title of certif	ier			29c. Licens	se number	2	9d. Date signed	(Month, D	ey, Year)
		1 hiliarl	Vacue	auth	ars	DIA	667		3-15	-99	,
10		30. Neme and address of person DR . MICHAEL	SCHWART			ype, Print) 'RITCHIE H	TGHWAY E	ALTIMORI	E MARYLA	AND 2	21225
Sta Regist		31. Date filed (Month, Dey, Yea MAR I 7 199	9 Se	32. Registr	ar's Signature	Spark					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death March 15, LeRoy Melvin Heath 1999 7:00 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6002 Alta Avenue Baltimore N/A If Under 24 Hrs. Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M M 2 ☐ F if Undar 1 Yaar 8. Date of Birth (Month, Day, Year) Dec. 25, 1930 7. Age (In vrs. last birthday) Days Months 68 006-22-9084 Yrs. Maine Usual Residence of Decedent 10d. Inside City Limits 10a Stata 10h Counts 10c. City. Town or Location 1 Yes 2 No Maryland N/ABaltimore 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21206 6002 Alta Avenue 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 12. Was Decedent Ever in U.S. Armed Forcas? 1 (X) Yes 2 □ No If Yes, Give KOTEAN Year or Datas Conflict 14. Race - American Indian, 11 Marital Status Black, Whita, atc. 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 XNo Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Driver Trucking 12th Grade 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Heath Daisy Ross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 6002 Alta Avenue, Baltimore. MD Mrs. Mary R. Heath (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 18 Burial 2 Cramation 3 Ramoval from State Garrison Forest VA Cem. 3/18/99 Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Addrass of Facility Schimunek Funeral Home, Inc. 21. Signatura of Funeral Sarvica Licensae 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final immediate disaase or condition rasulting in daath) 9 years Coronary Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disaase or injury that initiated avants resulting in death) Last Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Hypertension 2 🔀 No 1 ☐ Yes 1 ☐ Yas 2 ☐ No 25. Was case raferrad to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residenca 6 ☐ Othar (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA

Physician /Medical Examiner

Examiner

Be

permit. Page Department of Important: if any Injury or

Physician

/Medical

Examiner

Directo

Funerai

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: if then 27 Is marked other than "natural", or items 23s or 28e-f show mry or other transman be notified at mry or other traumatic event, in a Medical Examiner man be notified at

Baltimore, Maryland 21215-0020

sician and burial-transit physician s tha burial Physician/Medicai signed by the a Completed by is certificata has I director, page 2 s 2 Certification:

The law requires that the death certificata be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by tha funeral director.

Medical D

State Registrar

andra 31. Date filed (Month, Day, Year)



28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28d. Describe how Injury occurred

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29c. License number

29d. Date signed (Month, Day, Year) 3/16/99

D35363 who completed ceuse of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify)

28b. Time of

VA Medical Center 10 N. Greene St. Baltimore, MD 21201 Baltmore

MAR 1 7 1999

5 Pending investigation

6 Could not be

27. Mannar of Death

1 Natural

2 Accident

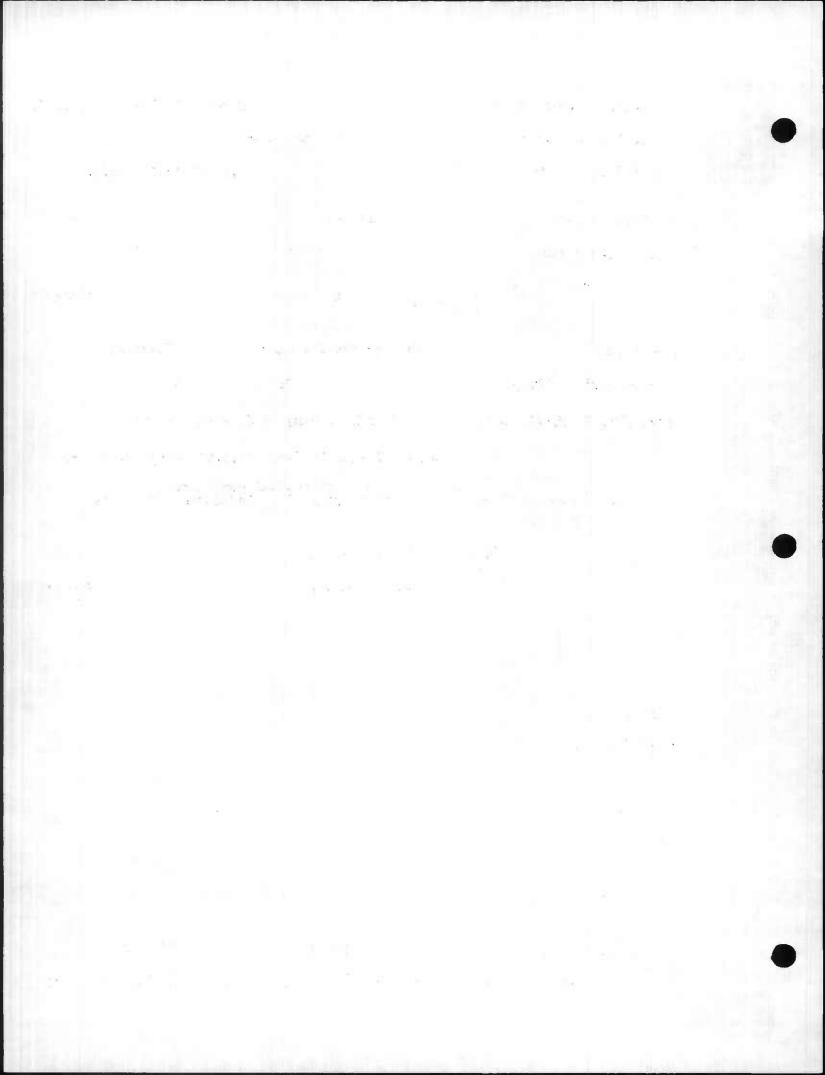
4 Homicida

30. Nama and address

29b. Signature and title of certifier

3 Suicide

29a. Cartifiar



Please	Туре	e or	Print	in	Black	Indelible Ink	. Assure	All Coples	Are L	egible.
					1 / 100		4 441 1			A

State of Maryland / Department of Health and Mental Hygiené (Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Herbert Dallie Hipsley 12:50 pm 1999 March 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Franklin Square Hospital Cer 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) t birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Baltimore 6. Sex 1 M 2 F Birthplaca (State or Foreign Country) Days 82 Maryland 10c. City. Town or Location 10d. inside City Limits

1 Yes 2 No

Approximata Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

23b. Did tobacco use contribute to the cause of death?

Funeral Director

Physician

/Medical

Examiner

Directo Funeral à Completed Be

with the Maryland Pages 1 and 2 should be filed within 72 hours aftar death with tha Marylar nant of Hatilh and Mental Hygiana. In this filem 21 is marked other than "natural; or items 23a or 28a-1 show int; if them 27 is marked other than "natural; or other treumatic event, the Modical Examines invaring the notified any

physician and the bunal-transit Tha law requires that the death cartificate be executed Division of Vital Records, P.O. Box 68760, 98 LSa is cartificata has l director, paga 2 or Attending Physician: funaral Aftar n 24 hours aftar daath.

• Funeral Director: Al daath. edicai complataly within 2

Important: if it any injury or o once. **Physician** /Medical Examiner Examiner Physician/Medical Completed by Be Certification: To

214-16-5413 Usual Residence of Decedent 10a State 10h County Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8509 Dempster Court, Apt. A 21234 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1X Yes 2 □ No If Yas, Giva Year or Datas: WW 11 14. Raca - American Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Firefighter Baltimore City 12th Grade 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Herbert Thomas Hipsley Emma Amelia Yakel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 8509 Dempster Ct., Apt. A, Parkville, MD 21234 Mrs. Mary A. Hipsley (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Othar (Specify) 3/17/99 Baltimore, Maryland Parkwood Cemetery 22. Name and Address of Facility 21. Signature of Funaral Sarvice Licensee Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line 21236 Immediate Cause (Final disease or condition rasulting in death) a. Respiratory failure
Dua to (or as a consaquence of): o Chronic obstructive Pulmonary disease Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consaquanca of)

Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. ZMM disea

1 Yee 2 No 3 Probably 4 Unknow 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was casa referred to medicel examiner? 26. Place of Death (Check only ona)

Hospital: Other: 4 Nursing Home 5 Residence 8 Othar (Specify) 1 Yes 2 No 1 Unpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ HomicIda

(Check only one) 29b. Signaturg entit stalet certifer

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

9000 franklin ORN Elicusson MD

31. Data filed (Month, Day, Yaar) MAR 1 ? 1999

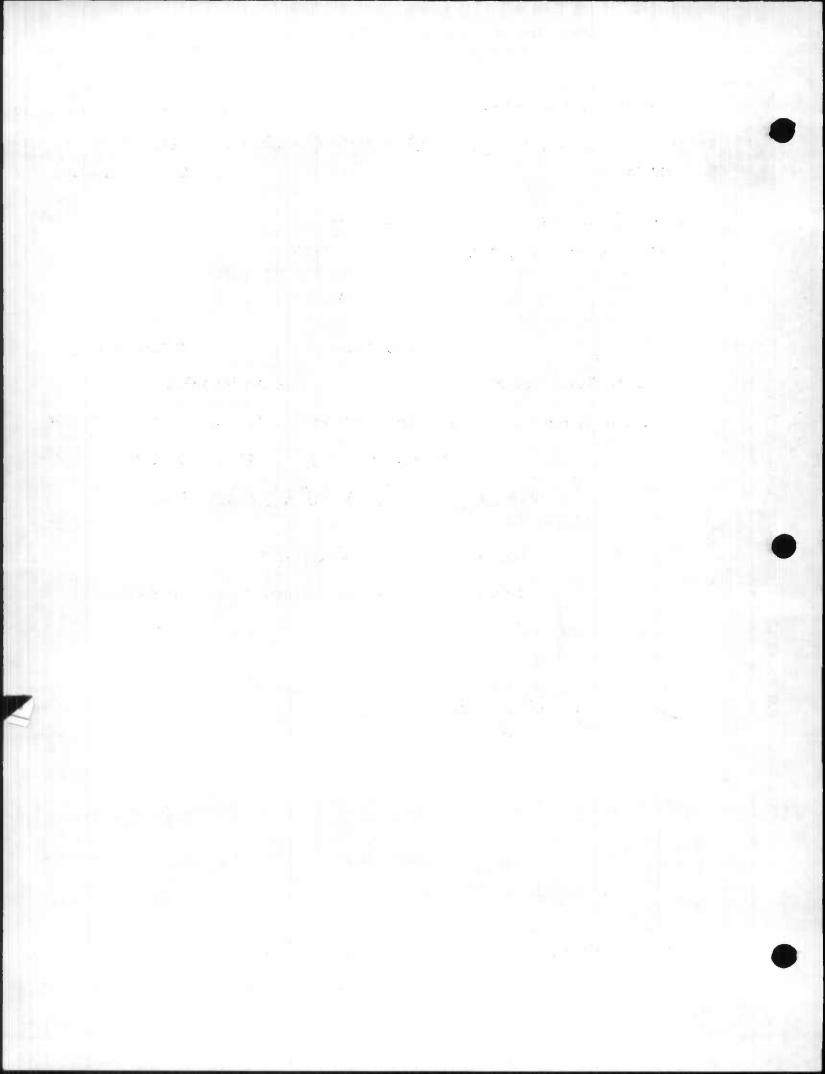
29a. Certifier

32. Registrar's Signature

Drive Baltimore, MD 21237

State

Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental	Hygiene q q	-0
Certificate of Death	Dec No.	U

8320 DOLORES WADDEL 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth MARCH 12, Dey 1999 Yeer 1130 AM **Physician** Waddell lores · /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number, Examiner 919 LYNDHURST STREET BALTIMORE If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year o (State or Foreign 6 Sax 9. 即 **Funeral** 1 M 2D Months Deys Hours 230-36-5905 Usual Residence of Decedent Yrs. Director the Merylend 10c. City, Town or Location 10a Stete 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Merylen Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be not treed. 1 Nes 2 No timore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 15A 14. Rece - American Indian, Street Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedant Ever in U.S. Armed Forces? 1 Yes 2 DNo If Yes, Give Year or Datas: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2NNo Baltimore, Maryland 21215-0020 Specify Specify: Black b 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Segondery (0-12) College (1-4or 5+) 134 lerk NA -overnme 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surnama) Be BULDE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Hamlet-Mcallyin 4/123 Eier

20b. Place of Disposition (Name of gemetary, cremetory or other place) Balto, MD 21206 20c. Location - City or Town, State 3 lenniece 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Park Render 15Town, MD 4 Donetion 5 Other (Specify) Men 22. Name end Address of Facility P. Wylie FIH, P.A. 21. Signeture of Funerel Service Licensee 23at Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. Atherosclerotic Cardiovascular Disease **Examiner** Due to (or es e consequence of): Examiner ettending physicien and for use es the bunel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebra vascular accident Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Wes en autopsy performed? Completed peen INSPECTION After this certificate hes 1 ☐ Yes 2 X No 1 Yas 28 No spital or Attending Physicien: Thours efter death.

neral Director: After this certificate yfilled in by the funeral director, pa Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient Other: 4 Nursing Home MResidence 6 Other (Specify) 2 fXXYes 2□ No 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Yeer) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde Hospital c To the Hospital within 24 hours e To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number O.C.M.E. MARCH 15, 1999 4011

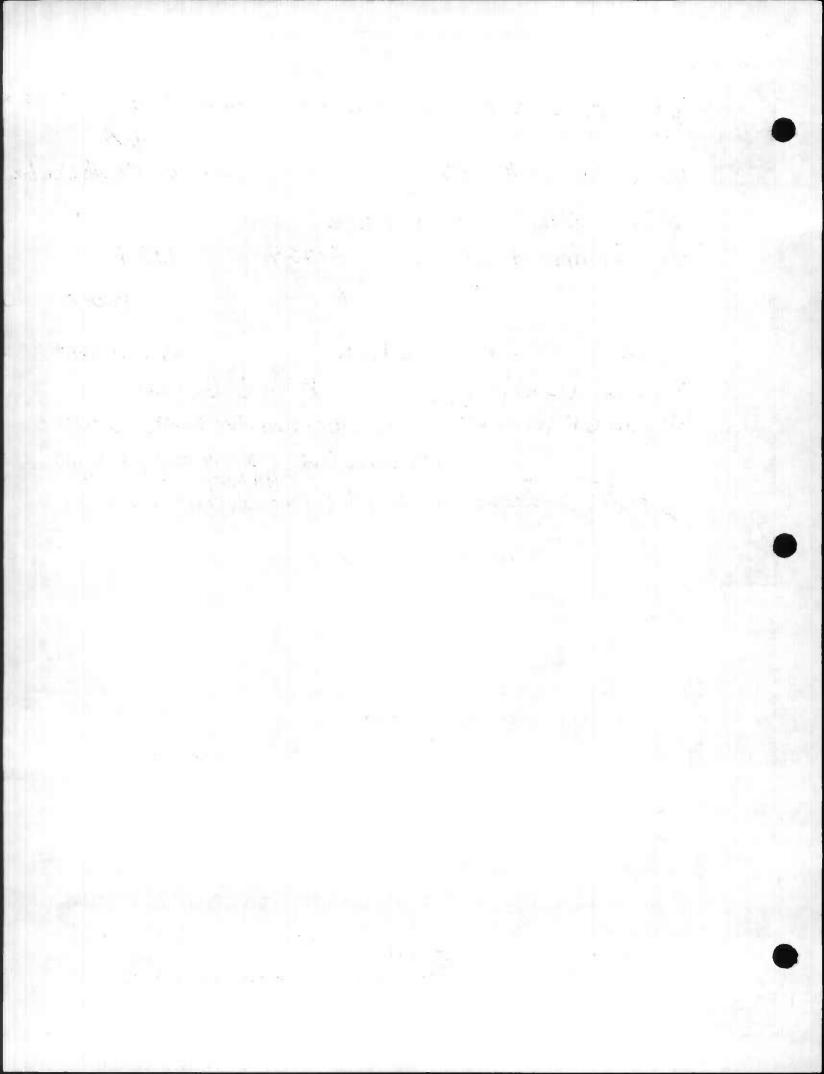
State Registrar 111 Penn Street, Baltimore, Maryland 21201

Strphen S.
31. Date filed (Month, Dey, Year) 32. Registfer's Signeture

30. Name end eddress of parson who completed cause of deeth (Item 23e) (Type, Print)

Radentz

1999 ▶ MAR 1



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth EDWARD MARCH 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE VETERANS HOSPITAL BALTIMOR N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) 65 Yrs. 5. Social Security Number Birthplece (State or Foreign Country) 10 M 2□ F 219-30-0434 April 5, 1933 West Virginia Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits N/A 1 XYes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 310 West 30th Street 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien Bleck, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ◯ No Specify: White 3 TWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Pressman Baltimore Business Form 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Parker Ingram Cleo Gray 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Perry Ingram (Son) 3152 Remington Avenue, Baltiomre, Maryland 21211 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem Gdns 3/18/99 Timonium, Md 22. Name and Address of Fecility 21. Signeture of Funeral Service Licensee A. Alan Seitz, Jr. Funeral Home l á 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Setween Onset end Deeth Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE MARCH 13, 1999 PULMONARY FIBRUSIS ITER STITIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Last Due to (or es e consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown heart failure 1 Yss 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Diabetes Mellitus 2 No 1 ☐ Yes 2 ☐ No 28. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA

Examiner Examiner ettanding physician and for use es the bunal-transit law requires that the death certificate be executed Physician/Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

with the Merylenc

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Merylen Depertment of Health end Mental Hygiane. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinating round to complete

Physician /Medical

signed by t

page 2 s

funeral

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Aftar

24 hours after death.

within 2 To the

or Attending Physician:

Hospital

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Completed

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Certification:

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical examiner? 27. Menner of Death

5 Pending Investigation 1 Naturel 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 Inpatient 2 ☐ ER/Outpetient 28e. Date of Injury

28h Time of

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) carlifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year)

28c. Injury et Work?

1 Yes 2 No

29b. Signature at

29c. License number M.D.

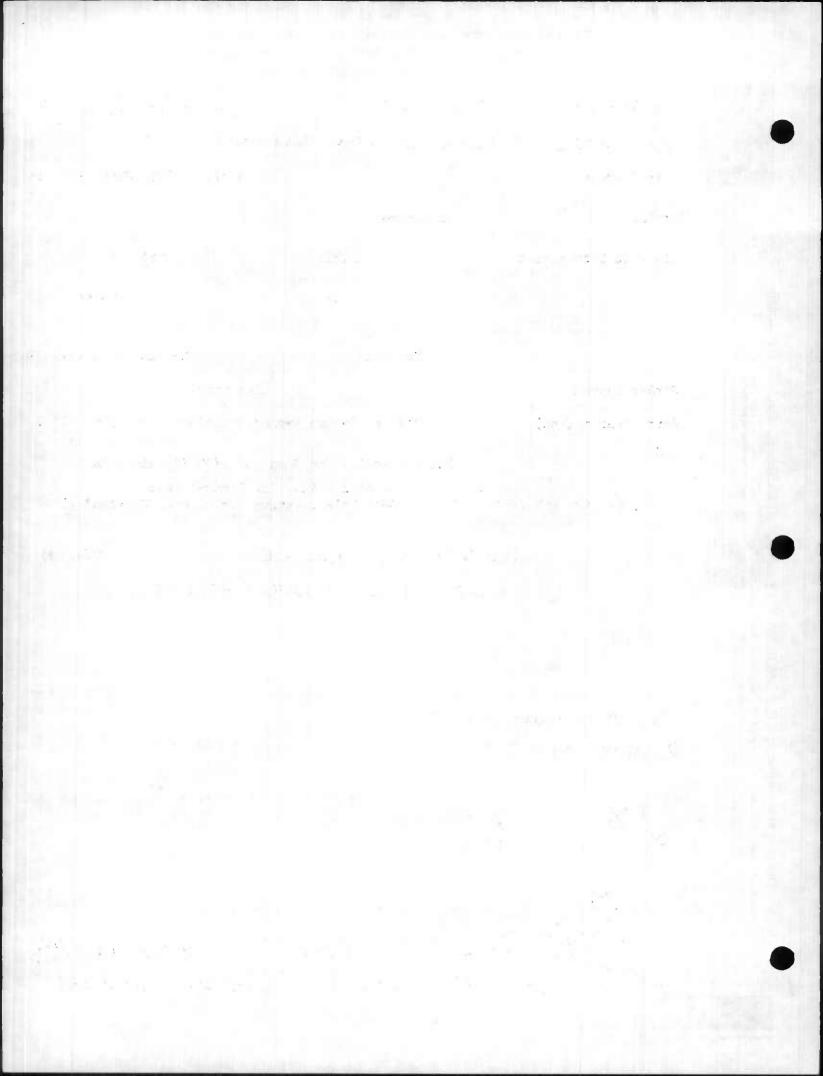
who completed cause of deeth (Item 23e) (Type, Print) 30. Name and

BALTIMORE, MD 2120 10 N. 31. Dete filed (Month, Day, Year)

State Registrar

MAR 1 7 1999





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Item: 8 per F.H G-769 3/17/99 reb Certificate of Death Rea. No 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Dev Month JZL 11,19 Richard ma 4b. City, Town, or Location of Deeth 4c. County of De 4e Fecility Neme (If not institution, give street end number) theres Randollstown tospi+ If Under 24 Hrs. 8. Date of Birth UKIN (Month, Dey, Yeer) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Days Min 186-20-8736 100M 20 F Months Hours Yrs. July 26,1929 Usual Residence of Decedent 10e State 10h Count 10c. City, Town or Location 10d. Inside City Limits Battimore 1 ☐ Yes 2 ☐ No Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6818 Yatanıba 2/20 Lan 12. Was Decedent Ever in U,S. Armed Forces? 1 I⊋Yes 2 □ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Status Bleck, White, etc. 1 Neyer Married 2 Married 1□ Yes 2DNo las Specify 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Baltimore Elementery/Secondary (0-12) College (1-4or 5+) fice, avages 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Margaret 19b. Meiling Address (Street end Number or Rufal Route Number, City or Town, Stete, Zip Code) 15204 19a. Informent's Name/Relationship (Type, Print) Purgh Pensylvania 20 Cocation - City or Toym, State BUM ratna Sister 20b. Placa of Disposition (Neme of cemetery, cremetory or other place 20a. Method of Disposition Date 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State furest Owings Mills MD. 4 Donetion 5 Other (Specify) Garison 22. Name end Address of Fecility Kevin 21. Signeture of Funeral Service Licensee Fureral 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in death) Intrevianial Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of) Due to (or as e consequence of): resulting in death) Lest Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probebly 4 Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24a. Wes en eutopsy 2 No 1 Yes 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental thygiene. Important: If Nem 27 Is marked other than "natural; or items 23s or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at an analysis.

Baltimore, Maryland 21215-0020

attending physician end for use es the bunel-fransit signed by the a should b hes t certificate he lirector, page

Physiclan/Medical Examiner The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, by Completed i or Attending Physician: efter deeth. Be 2 After this funeral Certification: efter deeth.

Director: Aft
d in by the fur

To the Hospital or within 24 hours eff To the Funeral DI completely filled in State

edical

29b. Signature end title of certified

7

5 Pending investigation

6 Could not be determined

25. Wes case referred to medical examiner?

31. Date filed (Month, Dey, Yeer) MAR 1 7

1 Yes 2 No

27. Manner of Death

1 Neturel 2 Accident

3 Suicide

29e. Certifier

4 Homicide

29c. License number

28c. Injury et Work?

1 Yes 2 No

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) 29d. Date signed (Month, Dev. Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stefe)

1 Inpatient

Dete of Injury (Month, Day

and menner steted.

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

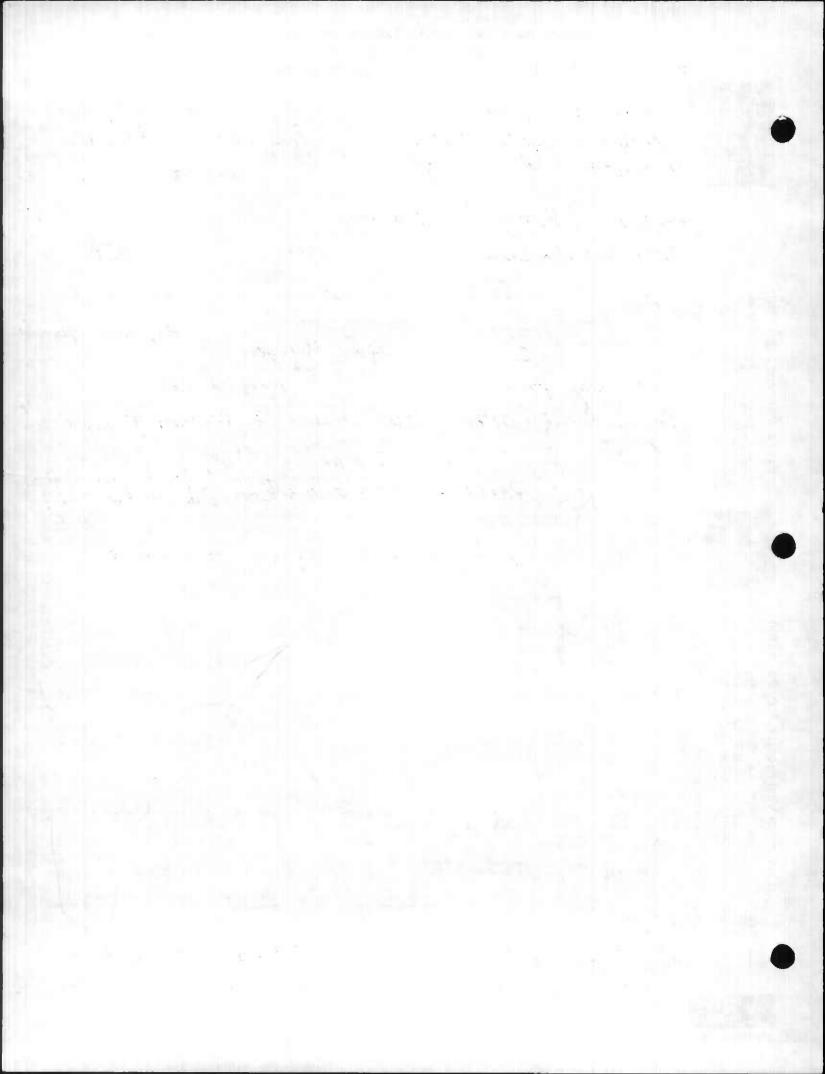
Hospitel:

NOVE 40 32. Registrer's Signature

2 ER/Outpetient 3 DOA

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Item 5 Pe	er F	H FilmG769 3-18-99	State of M	laryland /		tment of	Health and Death	Mental Hy	/giene	08	323
	Physicia /Medic	al .	1. Decedent's Name (First, Middle Ramona	Jones					2. Date of D Month Marc	eath Pay	Year 1999	3. Time of Death
	Examin Funeral Director		4e Facility Name (If not institution Un Ver Sity 5. Social Security Number ukn	of Mary	and go (In yrs. last b	virthday) Yrs.	If Under 1 Yea Months Day	BaH,	MOYE S. B. Date of B. (Month, D. JULY 1	irth Year)	9. Birthp Coun	lace (State or Foreign try) H CAROLINA
	anyland ahow		Usual Residence of Decedent 10e. State 10b. County		10c. City, To	wn or Loca	ation				10	0d. Inside City Limits
	with the Maryland a or 28a-f ahow be notified at	Directo	MARYLAND 10e. Street and Number		BALT	IMOR	10f. Zip Code			10g. Citizen of	What Coun	try?
	h with		612 PULASKI S	TREET			2121	.7	USA			
020	DO OZ	by Funeral	11. Merital Status 1 Never Merried 2 Nam 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	χνο χνο		es Decedent of Yes, specify Cu	Hispanic Origin? ban, Mexican, Puo o Specify:	No- 14. Race - American Indien, Black, White, etc. Specify: AFRO. AMERI		etc.	
15-0		Completed	15. Decedent (Specify only highes	's Education t grade completed)	16	a. Decede	nt's Usuel Occ	upation e during most of w	orking	16b. Kind of E	Business/Inc	lustry
212	Maryland 2121 d 2 should be filled within in and Mental Hygiene. 7 is marked other than "r traumatic event, the these		Elementary/Secondary (0-12)	College (1-4o	5+)		ISABILI					
			17. Father's Name (First, Middle,		ame (First, Middl	e, Maiden Suma	me)					
yla				DRE SR.				KATHE		OORE		
Mai	d 2 sh th and 7 is m traum		19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Sta 820 CATON AVE, BALTIMORE, MARYLAND									Code)
Baitimore,	Pages 1 and nent of Heel int: If item 2 ary or other		20a. Method of Disposition 1									
Bait	pemit. Pa Departmen Important: any Injury PDGS.		21. Signature of Funeral Service LLOYD M. ES					THERS FU			YLAND	21217
	Physician /Medical Examiner	ler.	23a. Part 1. Enter the disease or shock, or heart failure. List immediate Cause (Finel disease or condition resulting in death)	a. Sep	but the death. Do			ying, such es card		arrest,		Approximate Intervel Between Onset end Death
Box 68760,	ysicie	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6	Due to (or es a			Q ₁ S-Ca				
	the atter the atter	Scie	Part II. Other significant conditio	ns contributing to death	but not resulting	in the und	lerlying cause	given in Part I.	23b. Die	d tobecco use c	ontribute to	the cause of death?
s, P.O	as that the de igned by the be detached	y Phy	hepatitis						10	Yes ZNo	3 Prol	bably 4 Unknow
Records,	e law requires has been sign ge 2 should be	Completed by Physician/Med								s an autopsy formed?	ave	ere autopsy lindings eilable prior to mpletion of cause death?
al R	the h						17.1	- 77-16	10	Yes EX No	10	Yes 2□ No
Vital	3 0 5	Be	25. Was case referred to medical examiner?	Hospital:		7 - 1	-5	Wher	eeth (Check only			
o	After fune	tion: To	1 Yes 22No 27. Manner of Death 2 Netural 5 Pendin investig	28a. Date of In (Month, D	jury 28b.	Time of Injury	28c. In	4 LI Nursing	Home 5 Res	sidence 6 LJO		<u>n</u>
Division	pital or Attanditions after death.	Certification:	3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Plece of li	njury - At home, etc. (Specify)	farm, stree	et, fectory, offic	0		(Street and Num own, State)	nber or Rura	I Route Number,
	Hospi 24 hou Funer dely fill	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical I	Physician: To the bes Examiner: On the basis and menner s	of examinetion e	ge, deeth o	occurred at the stigation, in my	time, date end pla opinion, deeth oc	ce, end due to the curred at the time	e cause(s) and n n, date and place	nanner as si , and due to	ated. the cause(s)
	To the within 2 To the	_	29b. Signature and title of complex	. 118 M	N		29c. Lice	nse number		29d. Date sign	ed (Month,	Day, Year)

29d. Date signed (Month, Day, Year)

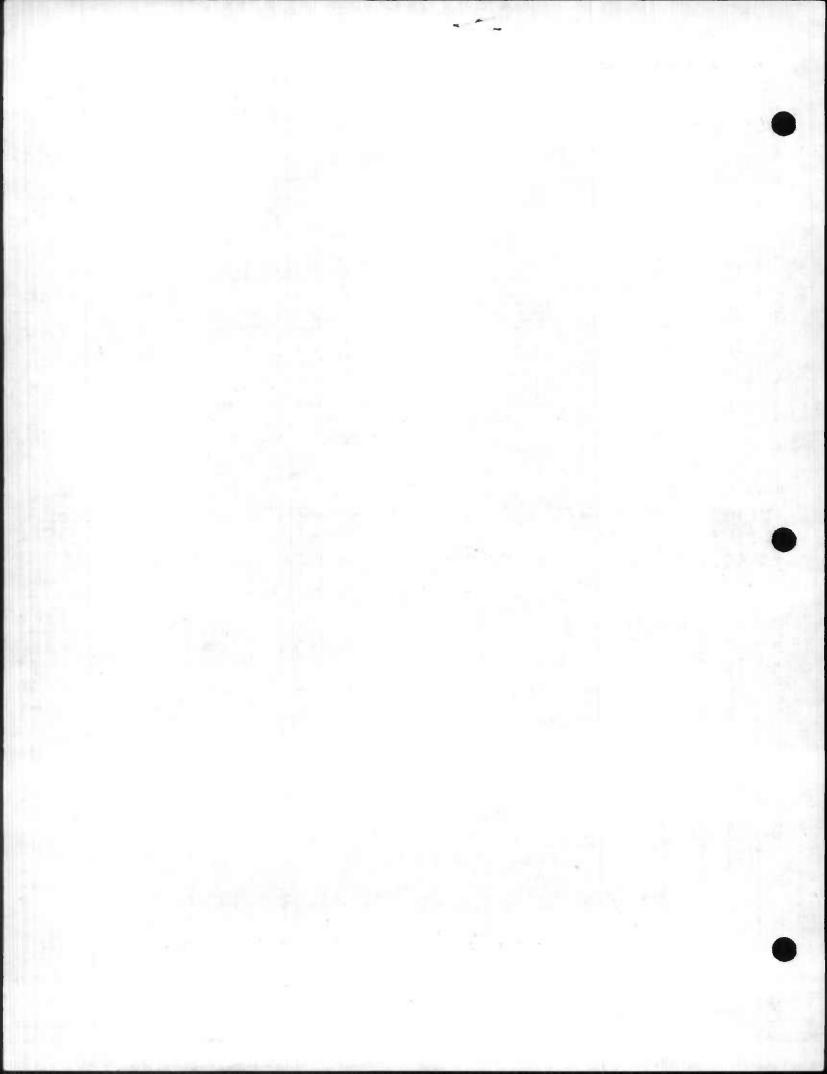
cause of death (Item 23a) (Type, Print)

Greene Street Baltinose, mo 21201

State Registrar

t 22 Sou 31. Date liled (Month, Day, Year) MAR 1 7 1999



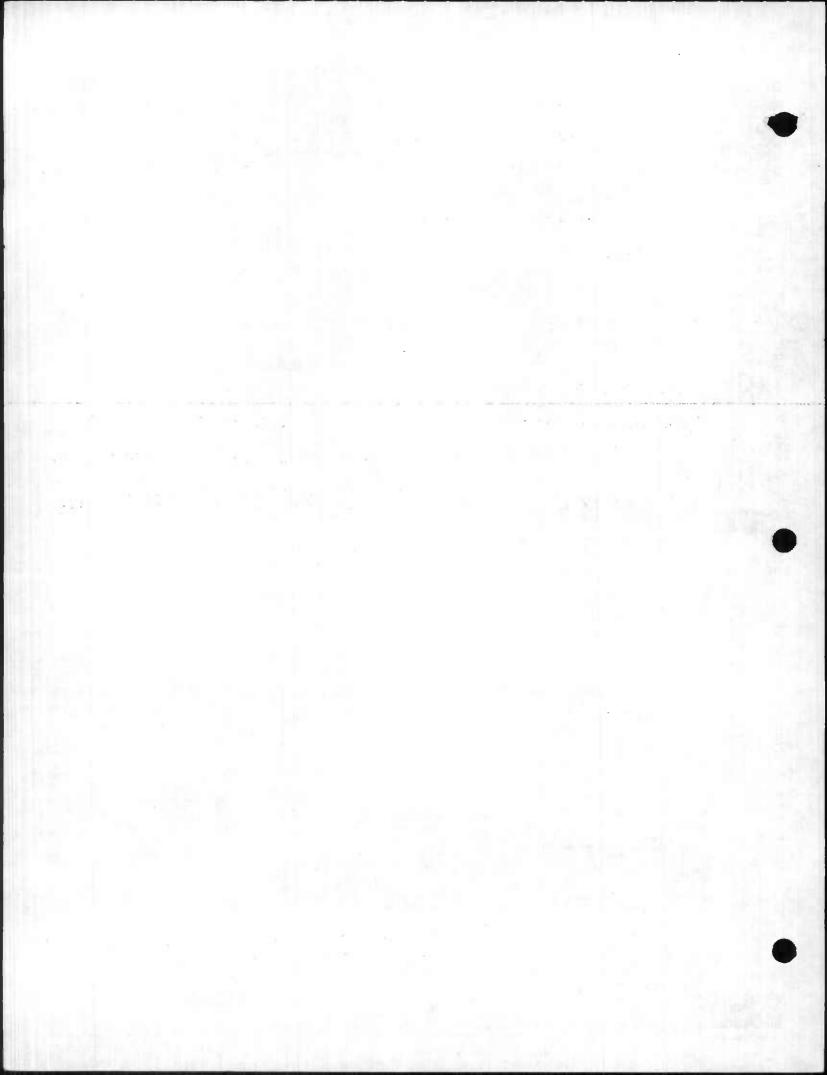


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) 9 08324

	Certificate of Death	Re	ng. No.										
Discolation	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	h Day Year	3. Time of Deeth									
Physician /Medical	ANNABELLE JONES	MAR. 1	2, 1999	9:15 P.M									
Examiner	4s Facility Name (If not institution, give street end number) 4b. City, Town, or	Location of Death	4c. County of Death										
9.	JOHNS HOPKINS BAYVIEW GEREATRICS BALTIM		N/A										
Funeral Director	5. Social Security Number 218-03-2151 B. Sex 1 Months Days Hours Min.		197, 1915°°	place (State or Foreign MD .									
2 .	Usuel Residence of Decedent 10a. Stale 10b. County 10c. City, Town or Location			40d Incide City Limits									
or the Marya or the feto be notified at Director	MD. BALTIMORE HARBOR VIEW PARK	10d. Inalde City Limits 1 ☐ Yes 2 ☐ No											
	10e. Street end Number 6902 FAIT AVE. 10f. Zip Code 21224		og. Citizen of What Cou	intry?									
Maryland 21215-0020 d 2 should be filled within 72 hours atter death of and Merital Hygiens. T is marked other than "natural", or here 23 traverselic event, the Medical Examiner must. To Be Completed by Funeral	11. Merital Status 1 Never Merried 2 Merried 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 No Specify: 13. Was Decedent of Hispanic Origin? (See Suppose	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Bleck, White, Specify: WH										
5-0 72 ho fical.	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	urkina 1	16b. Kind of Bustness/Ir	ndustry									
1.27215-0 ed within 72 to vgrens. we than 'natura' it, the Medical.	Elementery/Secondery (0-12) College (1-4or 5+) life. DO NOT use retired)	, and											
Cor things	7 HOUSEWIFE		DOMESTIC										
Be septime		me (First, Middle, M	laiden Sumeme)	en Surneme)									
Yie with Man To	2 JACK DAWKINS NORA SUMMER												
A Sah													
* 6 6 5 5	CONNIE GOLDENBERG/DAUGHTER 6902 FAIT AVE. B												
Saltimore amil. Pages 1. aportant if item ny injury or oth nos	20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILL CEMETERY		POC. Location - City or T BALTIMOR										
Ball parmit Depart Import any ini	4 Donation 5 Other (Specify) HOLLY HILL CEMETERY 3/15/99 BALTIMORE, MD. 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE. BALTIMORE, MD. 21.224 23a. Part. Films the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervel Between In												
Physician /Medical Examiner	transdiate Cause (Finet disease or condition resulting in death) a. CDR NARY ARTERY DIS	RAJR		Onset and Deeth									
D&/DU, tiflcate be associted tig physician and as the bunal-transit Aedical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):												
dS, P.O. BOX 687 iries that the deeth certificate signed by the attending phys d be deteched for use as the d by Physician/Medic	d	23b. Did tol	bacco use contribute t	to the cause of death?									
	DRMENTIA			obably 40 Unknown									
aw request been 2 should		24a. Wes an perform	C	Vere autopsy findings veilable prior to ompletion of cause I death?									
= F # & O		1 ☐ Ye	s 28No 1	☐ Yes 2☐ No									
sician: The certificate irrector, pa	Avaminor?	eth (Check only one	9)										
- K D		Home 5 ☐ Resider	nce 6 Other (Speci	ify)									
DIVISION O To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	27. Manner of Death 1 Netural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28c. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28d. Describe hore 28f. Location (Str. City or Town,	reet and Number or Rur	ral Route Number,									
Unite Hospital of the 24 hours aff of the 24 hours aff of the Puneral DI mpletely filled in Medical Cer	29a. Cartifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	e, and due to the caurred et the time, da	use(s) and manner as	stated. to the ceuse(s)									
the mple	one) and manner steted. 29b. Signature and title of certifier 29c. License number	20	d. Date signed (Month)	Day Yearl									
P 3 P 8	Marsher 1c Wildow D45757		WARCH 1										
3	30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) MATHEW & MCNASHY 4940 EASTERN	Me	PALS N	y 2/274									
State Registrar	31. Dete filed (Month, Day, Year) MAR 1 7 1999												

souls!



adentz

32. Registrar's Signature

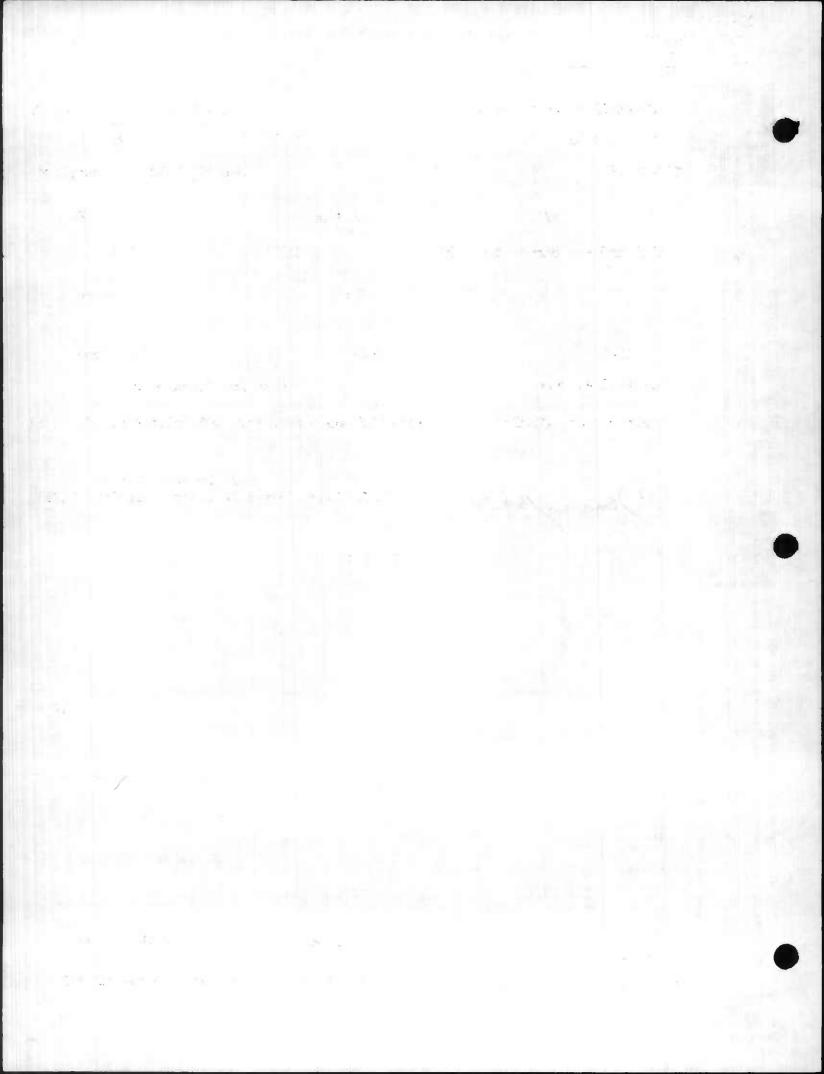
The man was

State Registrar

phen 31. Dete filed (Month, Day, Year)

MAR 17

1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Data of Death 330 pm Month **Physician** Bette MARCH JAMES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner BACTIVULE BALTIMORE mo Mercy HOSD HAZ If Under 1 Year | If Under 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dev. Yaar) **Funeral** Months Days Hours Min 1 M 2 XF Yrs 75 Director 212-20-9572 Usual Residanca of Daceden 5-17-23 VA the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d Insida City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exempter ment be not the 1 XYas 2 No Director MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2520 RIDGELY ST. U.S.A. 14. Race - American Indian, 21230 Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 □ Yas 2 [X] No if Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify þ 3

Widowed 4 □ Divorced BLACK Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondery (0-12) Collega (1-4or 5+) HOME MAKER HOME 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) UKN ALMA MOSLEY P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) IRENE SMITH 2520 RIDGELY ST. BALTIMORE MD. 21230
Disposition (Name of Data 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cematary, crametory or other place) 20a. Mathod of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata BALTIMORE NATIONAL CEM. 3-19-99 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE MD 22. Nama and Addrass of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MD. 21217 Tele Part 1. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** MYOCAMOIAL INTORCTION Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner OVAMAN CANCER attending physician and for use as the burial-transit requires that the death cartificate be executed Saquantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Diseese or injury that initiated events rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of): signed by tha a 23b. Did tobacco usa contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s cartificata has 2 No 1 Yas 219 No or Attending Physician: 25. Was case rafarrad to medical axaminar? funaral director. Be 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas / 2 No Certification: To Inpatiant 2 ER/Outpatient 3 DOA After this 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 5 Panding invastigation s after death. 1 | Yas 2 | No 2 Accident the 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Spacify) filled in by 4 Homicida Hospital 24 hours 1 Cartifying Phyeicien: To the best of my knowledge, daeth occurred et the time, dete end placa, and due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred et the time, dete and place, end due to the cause(s) and manner statad. 29e. Certifier Medical completely (Check only one) within 2

JOHN ANTONIOST

32. Registrar's Signatura

iss of parson who complated cause of death (Item 23a) (Type, Print)

N. Charles St Apt

W

507

Division of Vital Records, P.O. Box 68760,

State Registrar

29b. Signatur

30. Nama and add

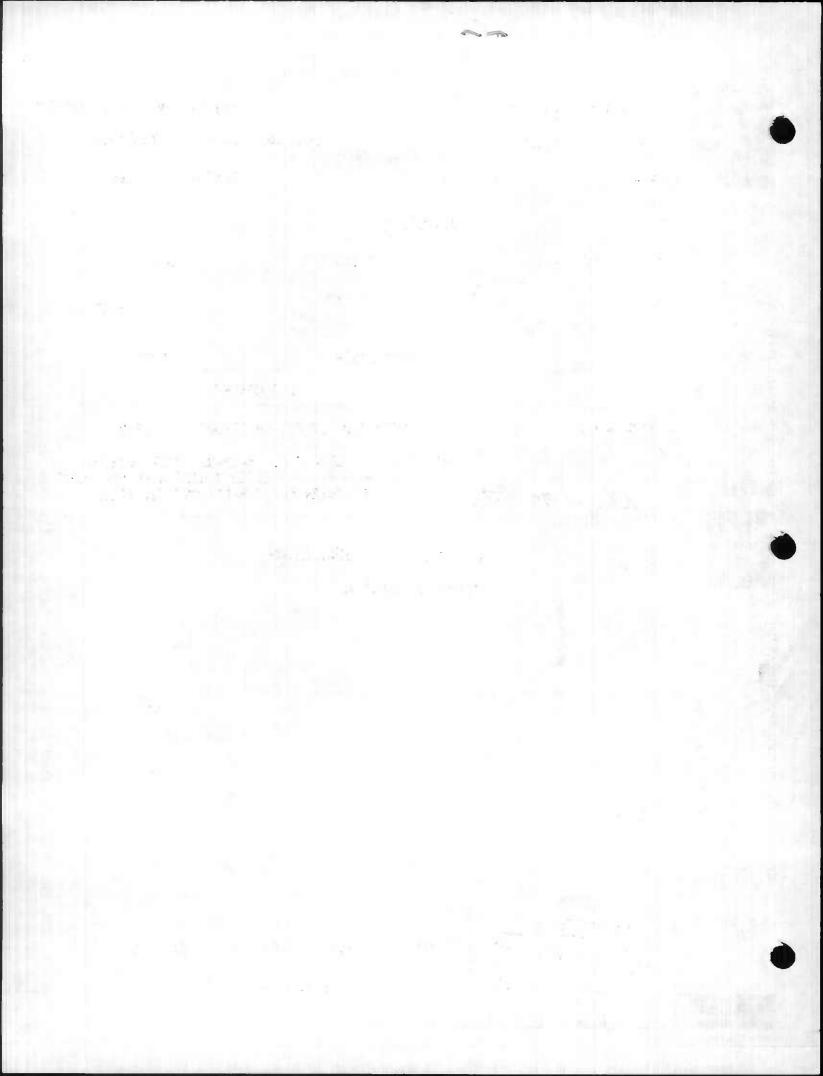
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DHMH 16 Rev 6/95

29c. Licansa number

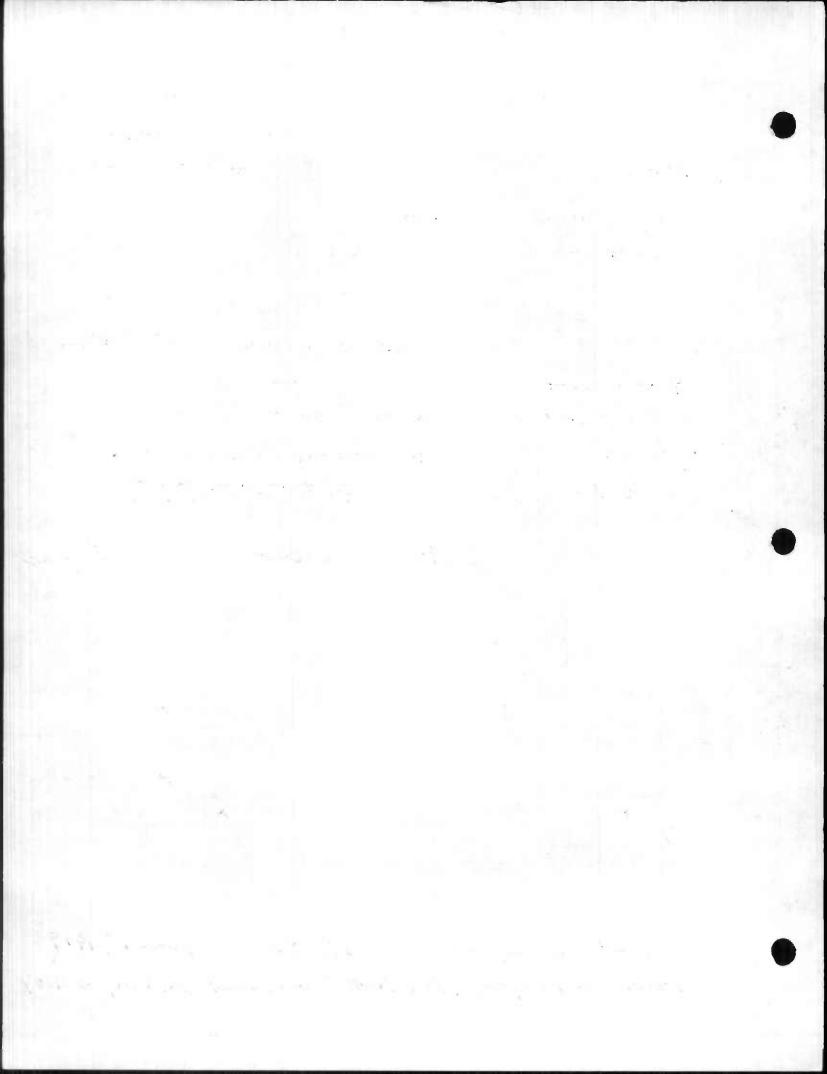
29d. Date signed (Month, Day, Year)

BATIMINE, MD 21218



State of Maryland / Department of Health and Mental Hygiene \(\text{Q} \) \(\text{Q} \) \(\text{Q} \)

46 Fischlip Manne (if not institution, give streat and number) 2602 John Dr. 2602 John Dr. 150 M 2Dr		1. Decedent's Nam		ast)					Death	2. Date of D	Davi	Was -	3. Time of Death
46 Facility Hame (if not institution, pive street and number) 46 Facility Hame (if not institution, pive street and number) 47 Facility Hame (if not institution, pive street and number) 48 Social Security Number: 49 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 41 Social Security Number: 41 Social Security Number: 42 Social Security Number: 43 Social Security Number: 44 Social Security Number: 45 Social Security Number: 46 Social Security Number: 47 Social Security Number: 47 Social Security Number: 48 Social Security Number: 49 Social Security Number: 49 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 41 Social Security Number: 41 Social Security Number: 42 Social Security Number: 43 Social Security Number: 44 Social Security Number: 45 Social Security Number: 46 Social Security Number: 47 Social Security Number: 47 Social Security Number: 48 Social Security Number: 49 Social Security Number: 49 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 41 Security Number: 41 Security Number: 42 Social Security Number: 43 Social Security Number: 44 Social Security Number: 45 Social Security Number: 45 Social Security Number: 46 Social Security Number: 47 Social Security Number: 47 Social Security Number: 48 Social Security Number: 49 Social Security Number: 49 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 40 Social Security Number: 41 Security Number: 41 Security Number: 42 Social Security Number: 43 Social Security Number: 44 Social Security Number: 45 Social Security Number: 45 Social Security Number	•	Edwar	d S. J	ohnson						March	15 1999	Yeer	2:25AM
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To Season and Season a		220-40-80	21			-				8. Date of Bi (Month, D Aug. 1	orth ey, Year) 9 1942	9. Birtho Cour Mar	place (State or Fore http:/ yland
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11. Martial Status	ecto			re	Pa	rkvill					10.000		
The comment of the	ral Dir										rog. Citizen o		ntry r
Albert W. Johnson 19a. Informerts Name (First, Middle, Last) Albert W. Johnson 19b. Informerts Name (First, Middle, Meader Sumanne) 20b. Method of Disposition 19b Brist 2 Coremains 19b. Method of Disposition 19b Brist 2 Coremains 19b Brist 2 1	6	1 Never Man		Armed Force 1 Yes 24 If Yes, Give	s? ⊠No	J,S. 13.				Specify Yes or Norto Rican, etc.)		leck, White,	etc.
1. Nother Name (Prist, Middle, Last) 18. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Middle, Medice Summer) 19. Mother Name (Prist, Medice N	2010	(Spe				16a. Dece	dent's Us	uel Occup	pation during most of w	orking	16b. Kind of	Business/in	dustry
Albert W. Johnson 19b. Informer's Name (Prist, Middle, Medden	DITT.	Elementary/Seco	ondary (0-12)	College (1-4d +2	or 5+)						Bell	Atlan	tic ompany
Albert W. Johnson Selectionship (Type, Print) 18b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)		17. Father'a Name	(First, Middle, Las	1)			-		18. Mother's Na	ame (First, Middle	, Meiden Sum	ame)	
19b. Melling Address (Street and Number City or Town, Stete, Zip Code) Mrs. Joan Johnson/ Wife 2602 John Dr. Parkville, MD. 21234 20b. Method of Disposition 1	0	Albert V	. Johnso	n					Edythe	Sherwo	od		
Signature of Funeral Service Licenses Set Air Memorial Gardens 3-18-99 Bel Air, MD.												m, Stete, Zip	Code)
Ruck Towson, MD. 21204 23a. Pert I. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval and shock, or heart feiture. List only one cause on each line. 23b. Deeth (or as a consequence of): Due to (or as a consequence of):		1 Burial 2	☐ Cremation 3 [te	cemetery, cre	metory or	other ple					
23s. Pert! Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval flat onselling in fellule. List only one cause on each line. Immediate Cause (Final disease or condition security in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Card Sequentially list conditions, and list of the cause (interval flat o		21. Signature of Fr	ineral Service Lice	nset &		2	2. Name	Rucl	Towson	Funeral	Home,	Inc. 21204	
24a. Wes en eutopsy performed? 24b. Wera autopsy evaliable prior to completion of cold death? 1	-	Sequentially list or if any, leading to in ceuse. Enter Undo Cause (Disease or that initieted event resulting in death)	enditions, nmediate orlying injury s Last	b	Due to (or as a conse	quence o	i):					
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25. Wes case referred to medical axaminer? 1	- Annaid		43									6/	railable prior to empletion of cause
1 Yes 2 SNo										10	Yes 2 No	11	☐ Yes 2☐ No
27. Manner of Death 1 Naturat 2 Accident 3 Suicide 4 Homicide 28a. Dete of Injury (Month, Day Year) 28b. Time ot Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 2 No 28c. Injury at Work? 2 No 28d. Describe how injury occurred		axaminer?		Hospitel:	tiont 3	TER/Outpotio	at 2□1	Ot Ot	aer.			What (Casa)	6.3
29a. Certifier (Check only only only only only only only only		27. Manner of Deat	h 5 Pending	28a. Dete of li (Month,	njury	28b. Time o	ot	28c. Inju Wo	ry at	-			97
29a. Certifier (Check only only only only only only only only	Certific			288. Piece of	Injury - At h etc. (Speci	ome, farm, st	reet, facto	ory, office				mber or Run	al Route Number,
CON Circum and City of an afficiant Court	odical	(Check only		miner: On the basis	of examine								
101010	X	29b. Signature and	title of certifier	1/81 gr			2	9c. Licen:	se number		29d. Date sig	ned (Month,	Day, Year)
290. Signature and title of certifier 290. Date signed (Month, Day, Year) 30. Name and address of person wholeompleted cause of death (Item 23a) (Type, Print) Robert Shepord MD, 6569 North Chortes Sheet, Baltimor, MD 21 31. Date filed (Month, Day, Year) 32. Registrar's Signetura		Koo	et Sh	part 1	2			DS	28/6		march	- 15)	1477



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Jefferson Mckinley 1245 AM 1999 March 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 F 5. Social Security Number 9. Birthplace (State or Foreign Funeral Days 219-38-9269 Usual Residence of Decedent Maryland Director 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show trsumstic event, the Macical Examinat must be notified at the Maryler 1 BYes 2 □ No altimore Director Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 1252 1202 Funeral death Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 4 Bace - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours effer on and Mentel Hygiene.

Is marked other than "natural", or iter 1 Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 à Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry UKN Elementery/Secondary (0-12) College (1-4or 5+) M 6 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kichard ena 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Depertment of Health and Important: If item 27 is a sny injury or other traun Balto. 20b. Place of Disposition (Name of cemetery, crematory or other place) 21202 VIVICO 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Eacility

23. Part Length disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock or mean failure. List only one cause on each line. Funeral Home & Services Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) SEPSIS 1 day Examiner Due to (or as a consequence of) Examiner ~ I wk PHENMONIA physician and s the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In deeth) Lest Due to (or es a consequence of): certificate be execu Box 68760, Physician/Medicai Due to (or es a consequence of): BS 980 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown scizure DIO multiple CVAs by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Type 2 Diabete Mellitres 1 Yes 2 No 25. Wes case reterred to medical examiner? Be 28. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Sinpatient 2 ER/Outpatient 3 DOA luneral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of tnjury (Month, Day Year) 28c. Injury et Work? Certification: After 5 Pending Investigation 1 Naturat i or Attending after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 ☐ HomicIde 24 hours a Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely To the Y within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12 199 AF 2664200 HS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date liled (Month, Day, Year)

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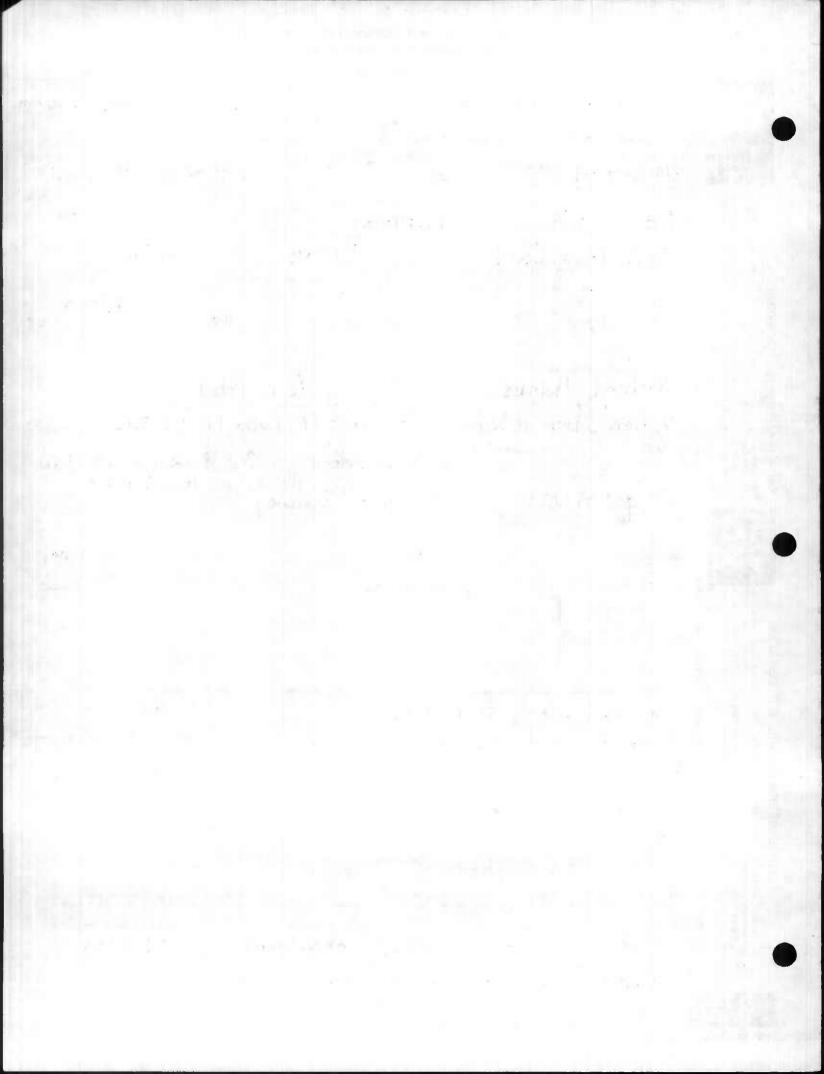
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32. Registrar's Signature

4940 Eastern Ave

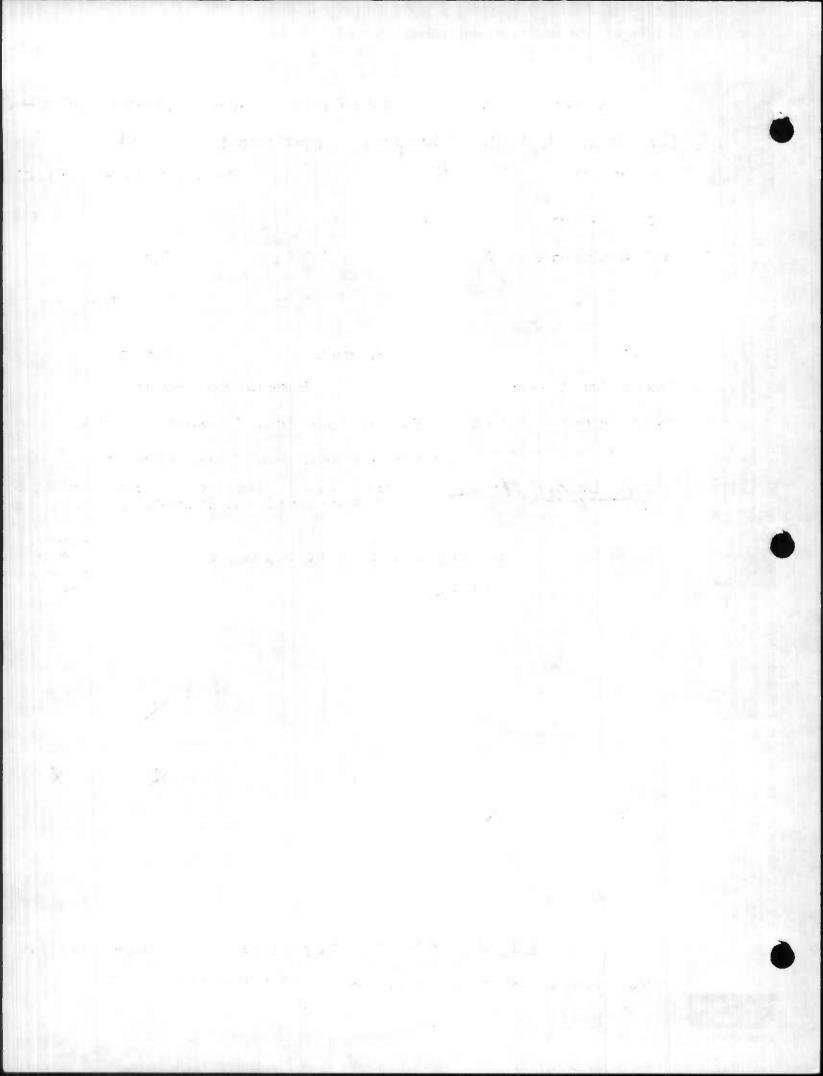
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uneral	5. Social Security Number 6. 5		yrs. last birthoay)	If Undar 1 Yaar If Under	er 24 Hrs. 8. Data of Bi	,	Birthplece (State or Forai Country)
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be notified Director	MD Howard 10e. Street and Number	J	essup	10f. Zip Coda		10g. Citizen of Wh	
3a or	8205 Washington	Blvd #9		20794		USA	,
free rount	11. Marital Status	12. Wes Decedent Eve Armed Forces?	r in U,S. 13. W	es Decedent of Hispanic C Yes, specify Cuben, Mexic	Origin? (Specify Yas or N		- American Indian,
or he	1 Never Married 2 Married	1 ☐ Yas 2 X No		Tes, specify Coben, Mexic			White, etc.
0	3 Widowed 4 Divorced	Year or Dates:		^			
	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decede	nt's Usuel Occupation ind of work done during me O NOT use retired)	ost of working	16b. Kind of Busi	iness/Industry
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W	19a. Informant's Name/Relationship			Addrass (Straet end Num			teta, Zip Code)
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5 = 5	20a. Method of Disposition 1 Durial 2 Cremation 3	Removel from State	cametery, crem	ition (Neme of etory or other plece) Washington	3/17/00		ity or Town, Stata
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w m	1 Yes 2 No	Hospitel: 1 Inpatient	2 ER/Outpatient		Nursing Home 5 ☐ Ras		7,
P P		28a. Date of Injury (Month, Day Ye	28b. Time of injury	28c. injury et Work? M 1 ☐ Yes 2[how injury occurre	a
leath. tor: After this the funeral di cation: To	27. Manner of Death 1 Naturel 5 Panding 2 Accident Investigation 3 Suicide 6 Could not extended.	28e. Place of Injury	At home, ferm, stre	et, factory, office			r or Rural Routa Number,
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DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ANDREW March 12, 1999 KRUG 11:25 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6129 N. Charles St. Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Devs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Deys Hours 1⊠M 2□ F Yrs 219-18-2246 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6129 N. Charles St. 21212 USA 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Status 1 Yes 2 No
If Yes, Give X
Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 M No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Horn, Dressel & Collega (1-4or 5+) Elamantary/Secondary (0-12) 12 Attorney Bennett 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surname) Krug Emma E. Andrew Torrence 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mrs. Jeanne F. Krug/wife 6129 N. Charles St. Baltimore, Md. 21212 20b. Place of Disposition (Name of cemetary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3/12/99 Timonium. Md. Dulaney Valley Memorial 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Congestive Heart Failure Immediata Cause (Finel disease or condition resulting in death) 8 years Dua to (or as a consequanca of): coronary artery DISCESE 8 years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in daath) Last Due to (or as a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Xee 2 No 3 Probably 4 Unknown cerebrovascular accident 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? prostate cancer 1 Yes 2 No Pepticulcer Disease 25. Was case referred to medical examiner? 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes > No 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Diviatural 5 Pending Investigation 1 Tyes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 4 I Homicide

Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Physician/Medical signed by the a þ been signature Completed s certificata has t Be 0 this After this Certification: or Attending after death.

Physician

/Medical

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or frems 23s or 28s-1 show injury or other fraumatic event, the Maylcal Examples or maribe mortified.

Division of Vital Records, P.O. Box 68760, Director: / To the Hospital or A within 24 hours after To the Funeral Directompletaly filled in by

State Registrar

edical

(Check only one)

29b. Signatura and titla of certifier Alukh mo 29c. License number 048050

Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

2205 iork Rd. 21093 I IMONIUM MD

PRASHAUT R. SHUKIA

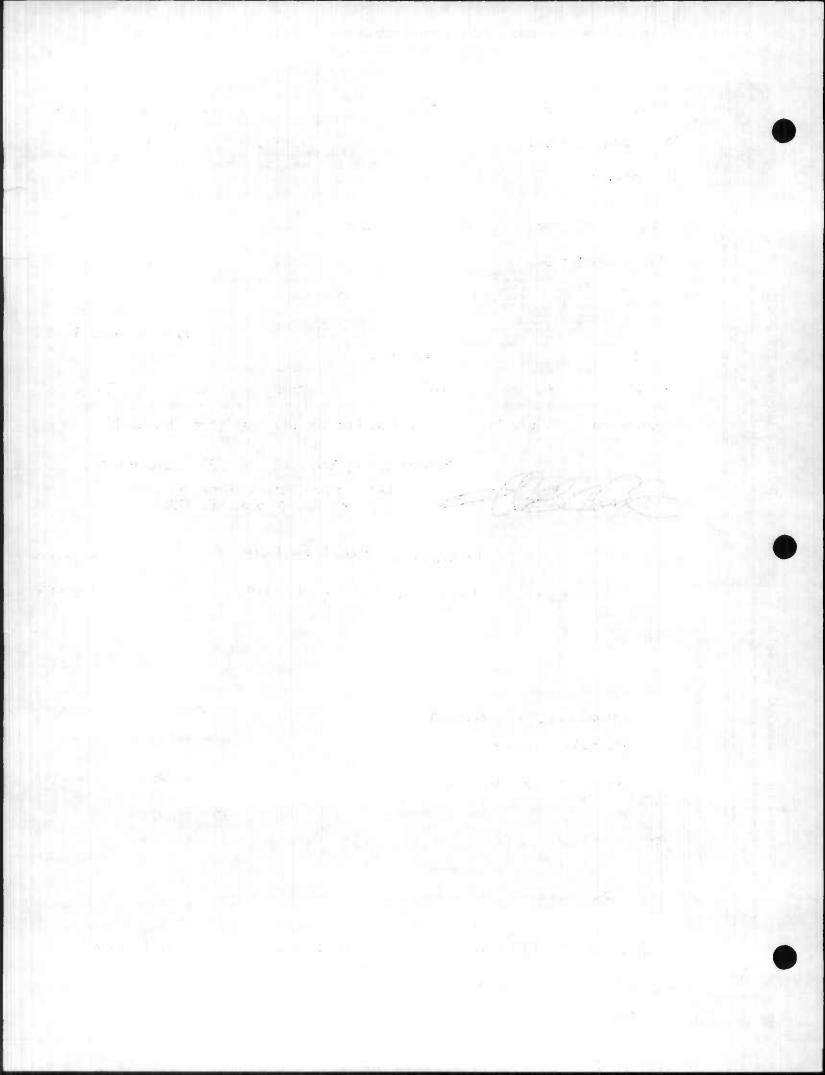
21043

31. Date filed (Month, Day, Year)

HAR 1 7 1999

Deaslean

3 Registrar's Signature



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day 1999 Month March 13, KTPP 3:45 AM CATHERINE 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Baltimore Stella Maris Hospice Timonium 8. Date of Birth (Month, Day, Year) Oct. 28, 10 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2X F 215-24-1700 Yrs. 69 Md Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 27 No Md. Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9 Cormer Ct. Apt. 102 21093 USA 14. Race - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Home maker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) George Fortmann Catherine E. Geary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Harry M. Kipp, III/son 2239 Port Lerwick Pl. Newport Beach, Ca. 92660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) Entombment Dulaney Valley Memorial 3/16/99 Timonium, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings avellable prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Domer (Specify) Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

certificate be executed

physician end s the buriel-transit Division of Vital Records, P.O. Box 68760, 50 esn 0 signed by the e page 2 hes certificate After this funeral or Attending efter death. Director: Aft Hospital

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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Examiner

Physician/Medical

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Completed

Be

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3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and tille of certifier

Funeral

Director

7 is marked other than "naturel", or items 23e or 28e-f show traumetic svent, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or ite

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any injury

Physician

/Medical **Examiner**

altimore, Maryland 21215-0020

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deeth

Certification: 24 hours Medical completely To the I within 2

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALTMOUD TARIO 31. Date filed (Month, Day, Year)

6 Could not be



and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

821 N. Entan St.

1 Certitying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

29c. License number

D43725

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) 29d. Date signed (Month, Day, Year)

Suit 316 Balkinese



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Data of Death 3. Time of Death Month MARCH 14, 1999 9:30 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) GENESIS EUDERCARE SEVERNA PARK ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) 1□M 2XF Months Yrs. 98 OCT. 2, 1900 AUSTRIA 215-50-0849 Usual Rasidence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yas 2 No MARYLAND ANNE ARUNDEL **PASADENA** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 309 DELMA AVENUE 21122 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work dona during most of working life. DO NOT use retired) (Specify only highast grede completed) Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) JOSEPH **JERICEK** ANNIE VONDRESKA 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) (DAUGHTER) 309 DELMA AVENUE, PASADENA, MARYLAND 21122 EMILY HUBE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 3/18/99 GLEN BURNIE, MD. 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 tagan Ou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between Onset and Death Immediate Cause (Final disaase or condition resulting in death) tension Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequanca of) 23b. Did tobecco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 20 No 1 Yas 25 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Sursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No Investigation

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Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

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Peges 1 and 2 should be filed within 72 hours after death a neat of Health and Mentel Hygiene.
wit: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, fre Mentel Engine man ury or other traumatic event, fre Mentel el Engine man

Important: If it any injury or o

Physician /Medical

Examiner

altimore, Maryland 21215-0020

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Certification:

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3 Suicide

29a. Certifier

4 Homicide

(Check only one)

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Box 68760 Division of Vital Records, Attending after death. Director: Aft the à 6 filled Hospital 24 hours pempletely To the To the To the F

Registrar

State

who completed cause of death (Item 23a) (Type, Print)

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Annupoli)

1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

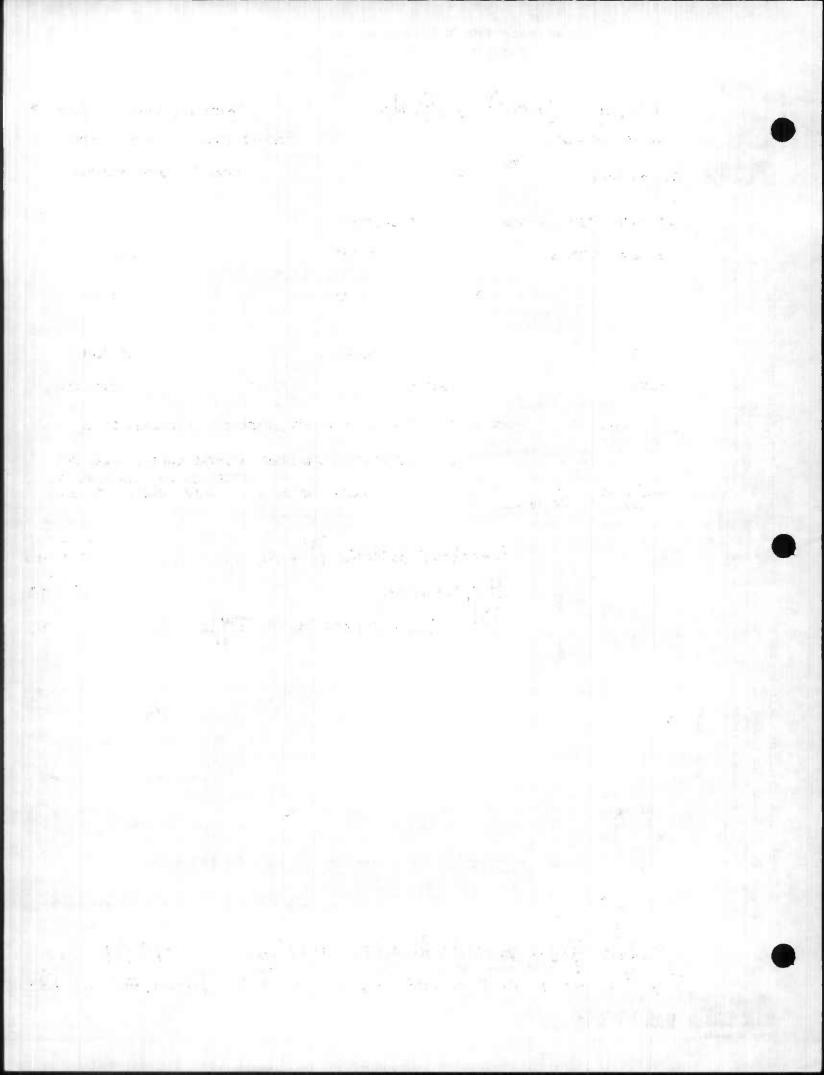
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

31. Date filed (Month, Day, Yeer)

6 Could not be determined

32. Registrar's Signature

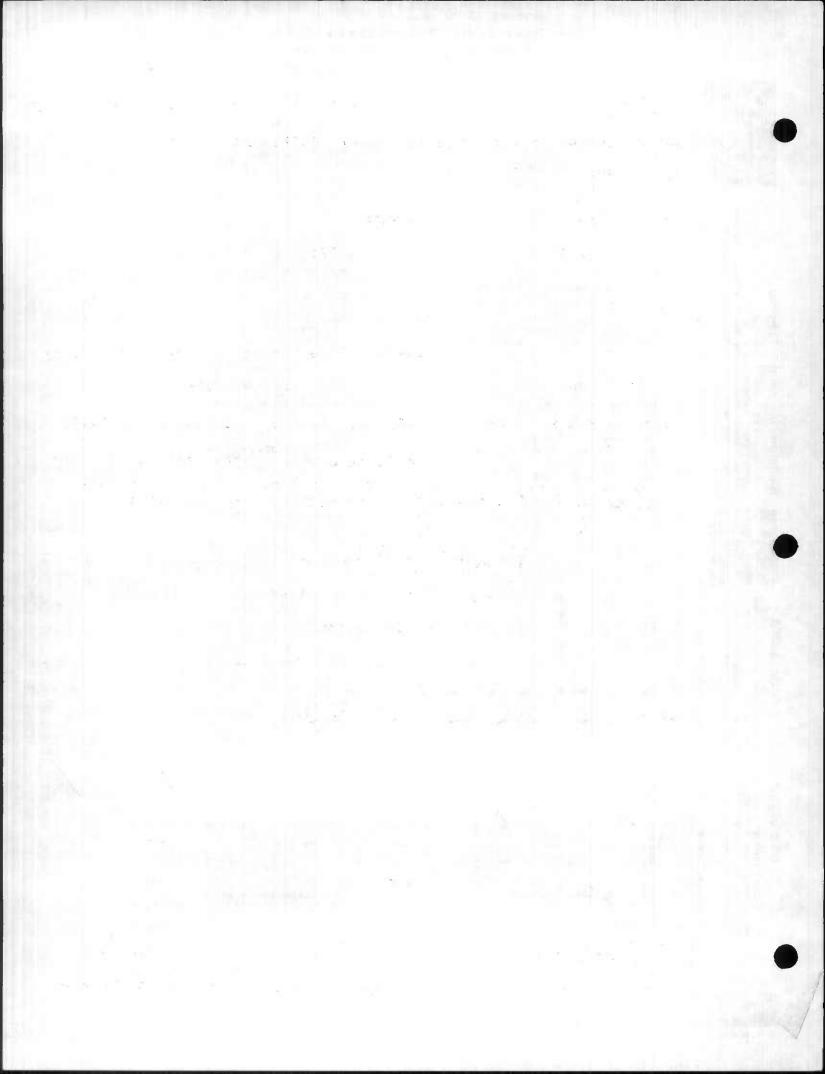


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Kempa 7:45 pm Betty March 1999 15 /Medical 4e Fecility Neme (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Johns Hopkins Bayview Medical Center N/A Baltimore 7. Age (In yrs. last birthdey) | HUnder 1 Year | If Undar 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foraign Country) **Funeral** 1 □ M 2)() F Deys Yrs 69 Director 217-26-2843 23 1929 June Usual Residence of Decedent with the Meryland 10c. City, Town or Location 10e. Stete 10b. County 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No N/A Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1440 Bonsal St 21224 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mantel Hygiane. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Experimental DOCS. Funeral 12. Wes Decedent Ever in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11. Marital Status Bieck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Marriad 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: þ White 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly line worker Chemical products 11 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) William Jann Lena Hargrove 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Michael Kempa 7823 Scholar Rd /son Baltimore, MD 21222 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Date March 19 1999 1 Buriel 2 Cremetion 3 Removel from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Metro Crematory Catonsville, MD 22. Name and Address of Fecility
Connelly Funeral Home of Dundalk 21. Signeture of Funerei Service Licenses onnell 23a. Part. Enter the disease, or complications that caused the death. A not entar tha moda of dying, such as cardiac or respiratory errest, shock, or heart failure? List only one cause on each line. 7110 Sollers Point Rd Approximete Intervel Between Onset end Deeth **Physician** immediate Cause (Final disease or condition resulting in death) /Medical Diretery Examiner Due to (or es a consequence of) Examiner Ence ettending physician and for use es the bunal-transit CYLC Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consegu certificete be Physician/Medical Dua to (or as a consequance of): ONOMER 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 9 1 Yee 2 No 3 Probably 4 Unknown 2 Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed certificate has No De 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) 1 Yes 2 No 27. Menner of Deeth Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After Naturel 2 Accident Injury or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No -0 -6 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Hospital Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) and manner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end manner steted. 29a. Certifie Medical (Check only one) within 2 100 29d. Data signed (Month, Day, Year) 29b. Signature & 29c. Licansa number D38670 MD 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Potes Berula 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

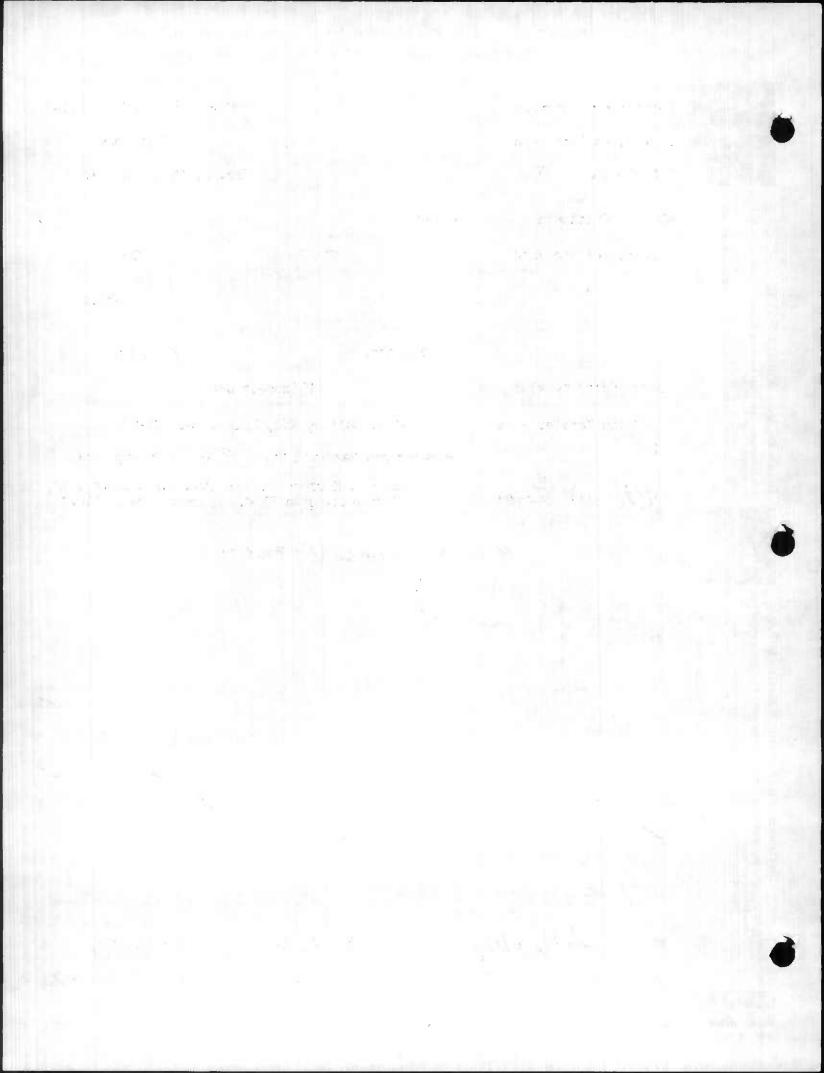
State Registrar

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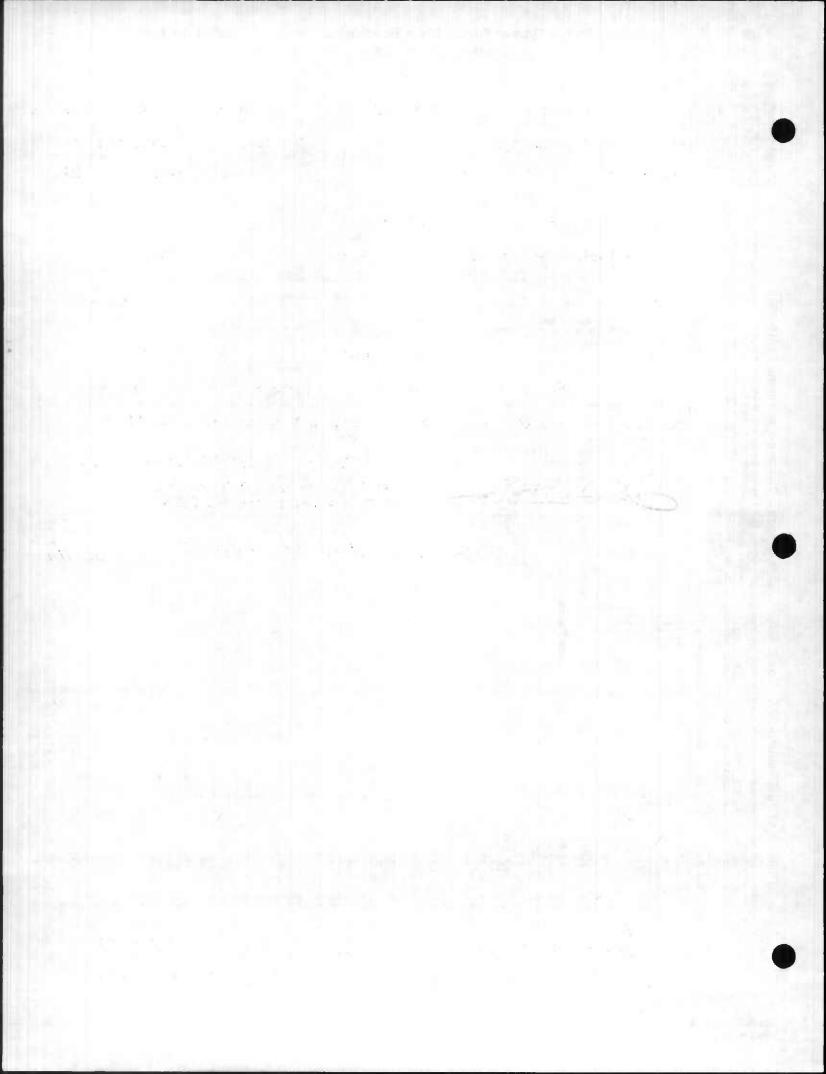


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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99-1509-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	d Mental Hygiene 9 9
LEITKOWSKI Certificate of Death	Reg. No.

Physician
· /Medical
Examiner

3. Time of Death 5:00P.M.

10d. Inside City Limits

Interval Between Onset and Death

White

1 Yes 2000

08336

Funeral

Director

with the Maryland Directo daath , Funeral ρ Completed

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

Be

To

Examiner

Physiclan/Medical

Ď

Completed

Be

To

Certification:

edical

3

To the Hospital within 24 hours To the Funeral Hospital

2 should be filed within 72 hours aftar and Mental Hygiena. Is marked other than "naturel", or ite Baltimore, Maryland 21215-0020 permit. Pagas 1 and 2 sh Department of Haaith and Important: If item 27 is m any Injury or other traum once. **Physician**

Examiner the attanding physician and hed for usa as the burial-transit cartificata be axecuted Box 68760. P.O. signed by Division of Vital Records, peen cartificata has this funeral Aftar death. aftar death

/Medical

2 Date of Deeth 1. Decedent's Name (First, Middle, Last) 14, 1999 Michael Joseph Leitkowski MARCH 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 7 HOLCOMB COURT **ESSEX** BALTIMORE If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Months Days Hours Min. 1⊠M 2□ F Yrs. 218-58-8272 Dec. 1,1954 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Middle River Maryland Baltimore 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 7 Holcomb Court 21220 United States 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Printing Company 12 Years Pressman 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Ellen Burke Joseph Leitkowski 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 436 Haslett Road Joppa, Maryland 21085 Mr. William S. Leitkowski 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 3/20/99 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the definance of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart to the burner burner burner to the course on each line. ardio ascular Immediate Cause (Final disease or condition resulting in deeth) Crosc 0 Due to (or es e consequence of): Sequentially list conditions, it eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): that initiated events Due to (or es e consequence of):

rosaling in acciny East			
	d		
Part II. Other significant con-	ditions contributing to death b	out not resulting in the underlying ceuse (given In Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown

24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 24a. Was an autopsy performed? 2□ No 1 Yes 2□ No

25. Wes case referred to medical examiner? 1 X Yes 2 □ No 27. Manner of Death

1 MNatural

2 Accident

4 Homicide

3 Suicide

Hospitel: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

Other: 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Yes

26. Place of Deeth (Check only one)

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

1999

5 Pending Investigation

6 Could not be

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

MARCH 15, 1999

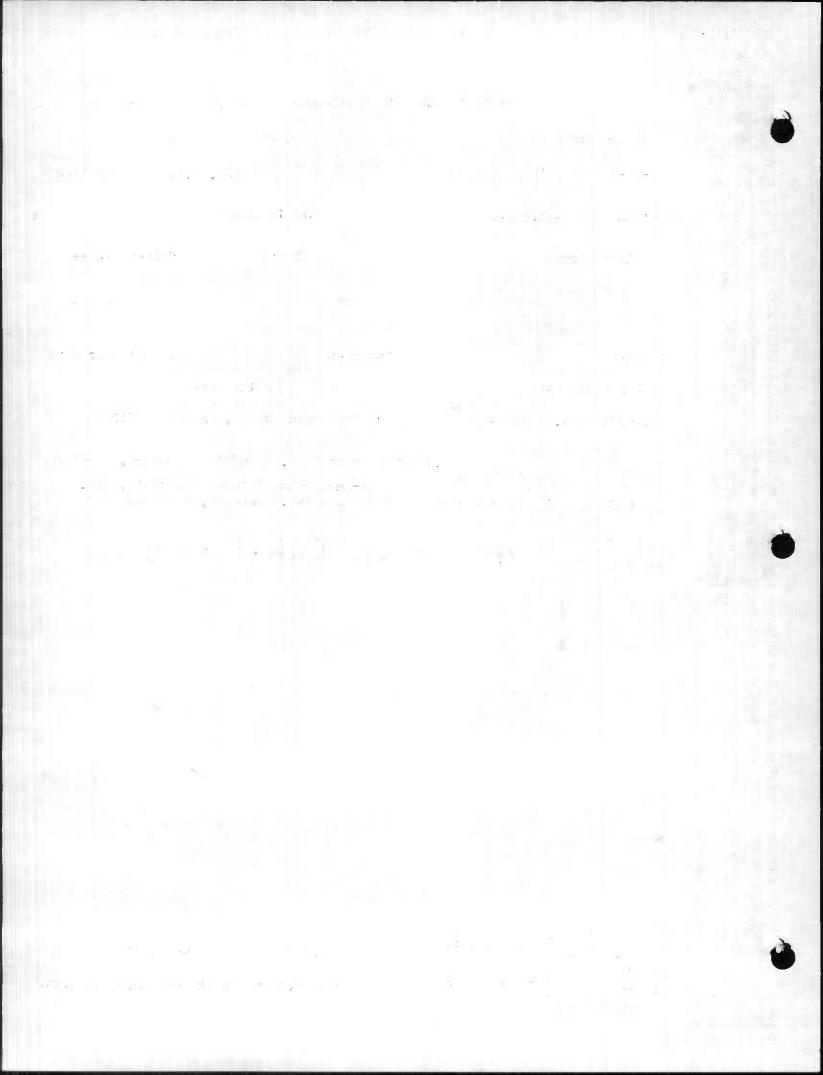
Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and #ddi s of person who/completed cause of deeth (Item 23e) (Type, Print) estaner

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Registrar's Signeture oaks

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)



State Registrar

DHMH 16 Rev 6/95

ess of person who completed cause of death (Item 23a) (Type, Print)

5

DSC

31. Dete filed (Month, Day, Yell)

MAR 1 7 999

taner

32 Registrar's Signature

Hali"

	1. Decedent's Name (First, Middle						2. Date of De Month	ath	V.		Time of Death
cian	MYRTLE	LAG	. ES .				MARCH	DayH	19	99 2	:15 Am
ical iner	4a Facility Name (If not institution	, give street end number)				b. City, Town, or L			unty of [
	NORTHWEST	HOSPITAL		NIER		RANDALL		100		MORE	
	5. Social Security Number	4 T M OFF	yrs. last birthd	Months		If Under 24 Hrs. Hours Min.	(Month, Da	th y, Yeer)	9.	. Birthplace (Country)	Stete or Foreign
	212-05-1553	87	Yrs	S.			Dec. 24	+ , 191	1	Mary	land
-	Usual Residence of Decedent 10e. State 10b. County	100	. City, Town o	or Location						10d In	side City Limits
	22.030										Yes 2 No
5	Maryland Balt:	imore		Rockdale							
Director	10e. Street and Number			10f. Zip Co				10g. Citizer		at Country?	
<u>a</u>	3610 Lang	grehr Road		21	124	4		U.S.A	1.		
Funeral	11. Marital Status	12. Wes Decedent Ever i Armed Forces?	in U,S.	13. Was Decedent	t of Hi	spanic Origin? (Sp	pecify Yes or No	· 14.		American Inc White, etc.	dien,
	1 Never Married 2 Marr						rtiouri, oto.,			**************************************	
2	3 XWidowed 4 ☐ Divorced	Year or Dates:		1□ Yes 2፟⊠	7 1/10	Specify:		Sp	ecity:	White	e
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Completed	(Specify only highes	1	(G	Give kind of work of fe. DO NOT use t	retired	iunng most of wor)	ung				
5	Elementary/Secondary (0-12)	College (1-4or 5+)		Supervis	sor			Tele	pho	ne Com	pany
	17. Fether's Neme (First, Middle,					18. Mother's Nam	ne (First, Middle		-		
0						Doh	00 D	011	M	**	
1	Arbie Filmon		T	4-112 A A A	20.	Rebec		ell	Mui:		
	19e. Informant's Name/Relations			Mailing Address (S							"
	Mr. James Robe:			27 Buckne			Baltimo			1206	
	20a. Method of Disposition	2 DRamaval from State	Db. Place of Di cemetery,	isposition (Neme cremetory or othe	of or place	(e)	Dete	20c. Loca	ion - Cit	ty or Town, S	itete
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 Linemoval from State							-	Mana 1	0 - 1
-		DECHY)	Baltimo	ore Wash:	ing	ton Crem	3/16	Lauı	el.	Marvi	and
- 1	21. Signature of Funeral Service		Baltimo		_	ton Crem				Mary1	and
	21. Signature of Funeral Service		Baltimo		_	ton Crem ss of Facility rs Funer					and
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	21. Signature of Funeral Service: 23a. Part1. Enter he disease, or shock, or heart failure. List	Licensee Jes	Kins	22. Name and A Loring 1 8728 Lil	Addres Bye ber	rs Funer ty Road	al Dire Randal	ctors:	In	C. D 211	. 33 roximete val Between
	Stepher	Licensee Jes	Kins	22. Name and A Loring 1 8728 Lit t enter the mode o	Address Bye ber	ss of Facility TS Funer ty Road g, such as cardiac	al Dire Randal or respiretory e	ctors	In	C. D 211	.33
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plece, end due to the cause(s) and manner stated. PHYSICIAN 29c. License number 29d. Date signed (Month, Dey, Year) HOUSE D 42723

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AVVERAKALLI HARISH

3745 FOXFORD BAZTIMORE

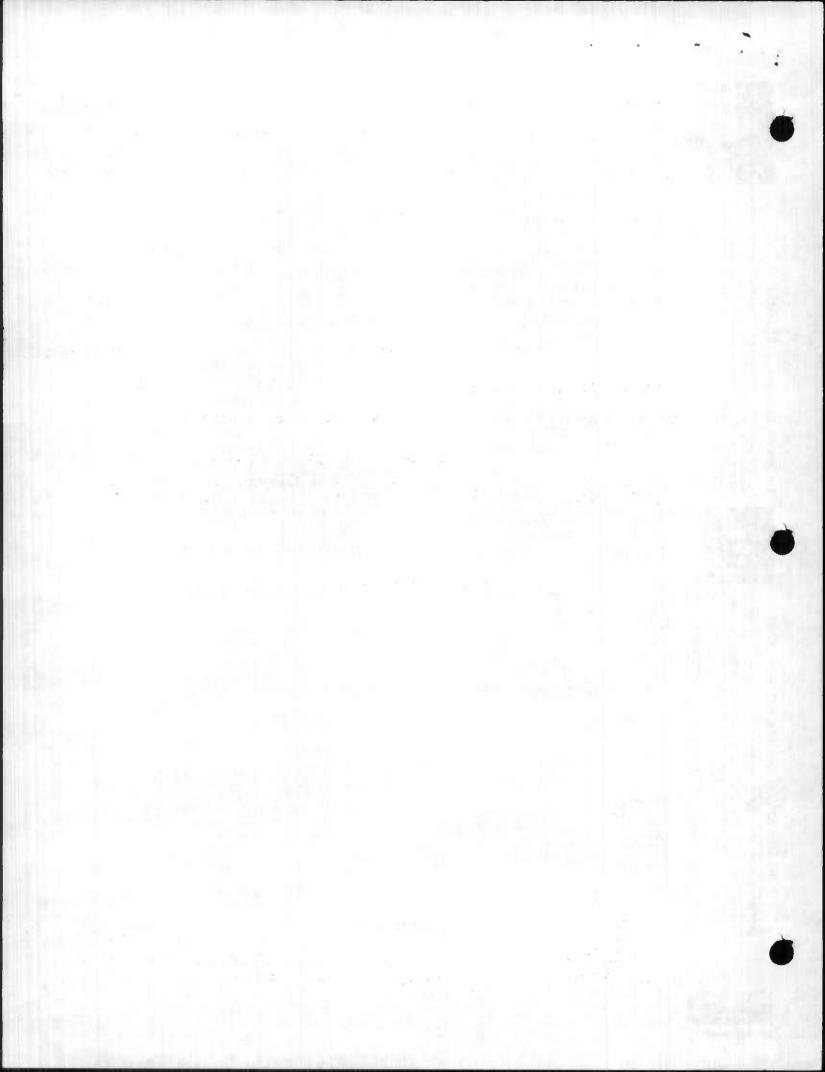
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Registrar







Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1 Decedent's Neme (First Middle Last) 3. Time of Deeth **Physician** JOHANNA H. MCCANN 3:55 PM MARCH 13, 1999 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** GILCHRIST HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1□ M 2√2 F 220-14-5135 73 Yrs. **Director** JULY 17,1925 MARYLAND Usual Residence of Decedent 10e Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo BATITIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1706 HOLAVIEW ROAD APT. C-3 21222 U.S.A. Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) than "natural", or items the Medical Examiner m 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE py ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CLERICAL GOVERNMENT 12 / is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be FREDERICK HILL DORA FLAMM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) SUSAN MEAGHER- DAUGHTER 4112 GLADDEN AVENUE BALTIMORE, MARYLAND 21213 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE, MARYLAND OAK LAWN CEMETERY 3/17/99 22. Name end Address of Fecility 21. Signature # Funeral Service Licensee CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MD 21224 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Adenocarcinoma Examiner 2 months Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medicai Due to (or as e consequenca of): 98 23b. Did tobacco use contribute to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? 2.0 No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28b Time of 28c. Injury at Work? Certification: 28e. Dete of Injury (Month, Day Year) 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

Johanna McCan

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29e. Certifier

(Check only one)

29b. Signeture and title of certifie

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29c. License number

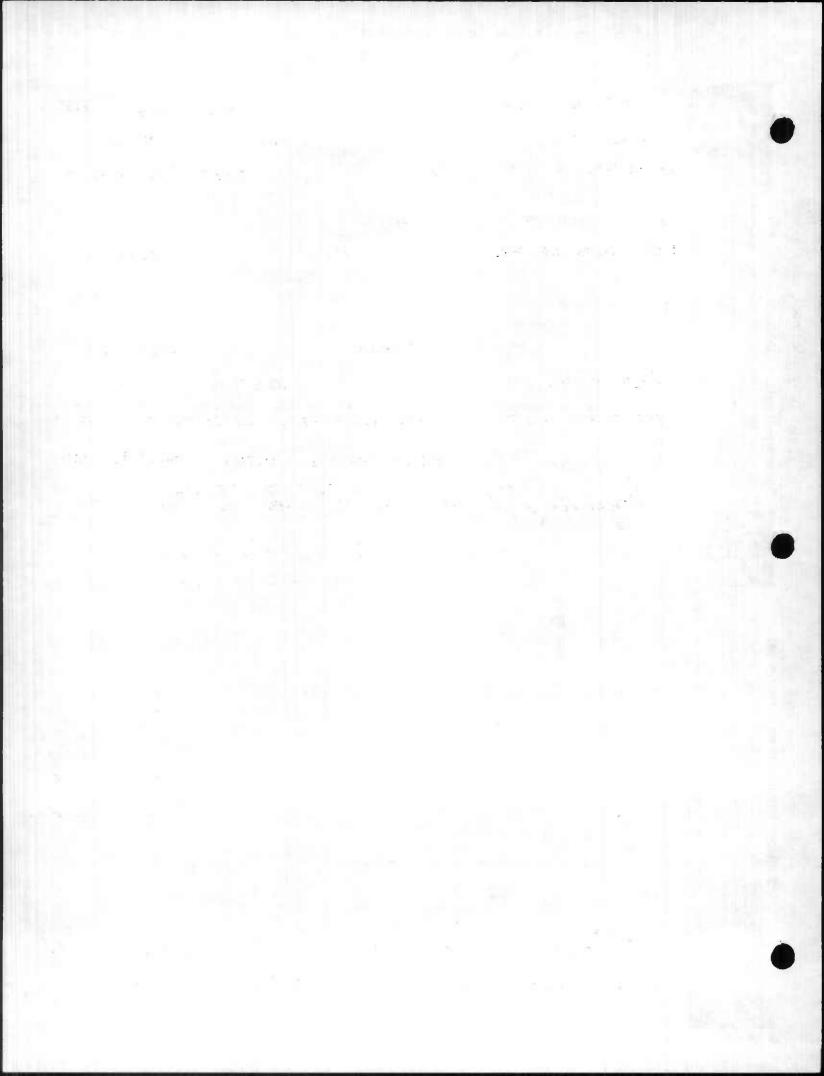
29d. Date signed (Month, Day, Yeer) March 14, 1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

N. Charles St. Balto. Md 21208 Riley GBMC 6701 31. Dete filed (Month, Day, Year)

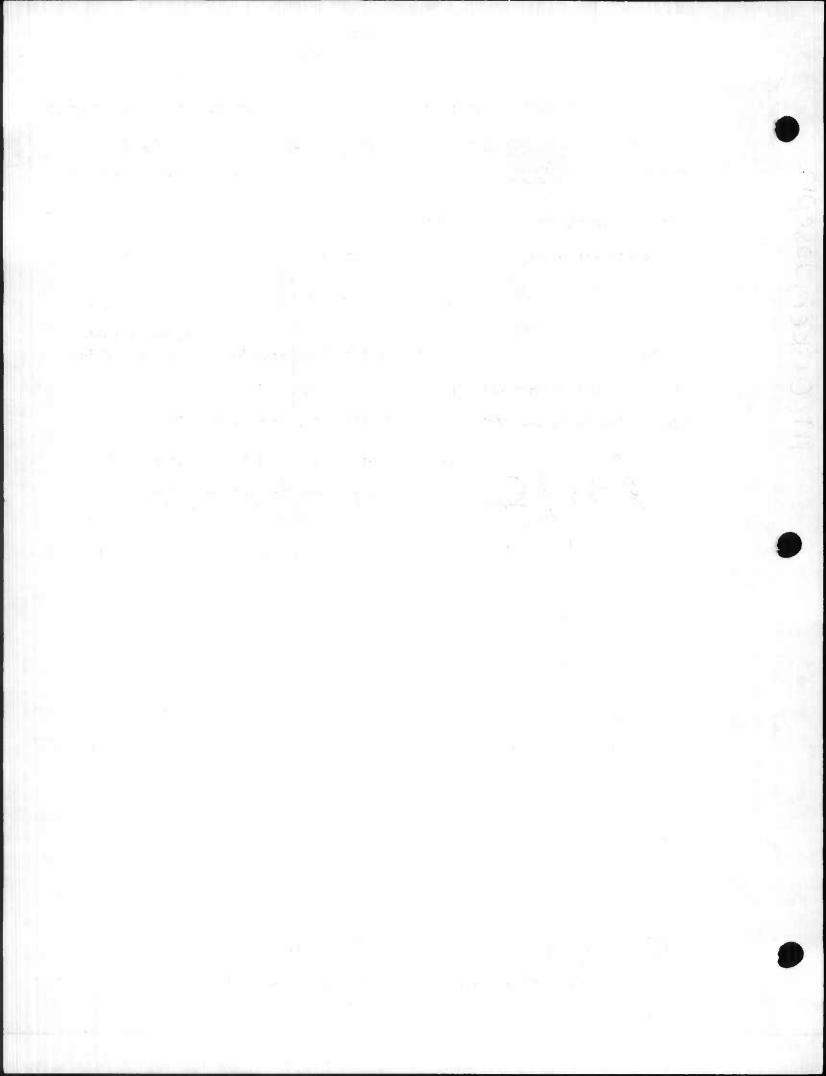
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32. Registrer's Signeture



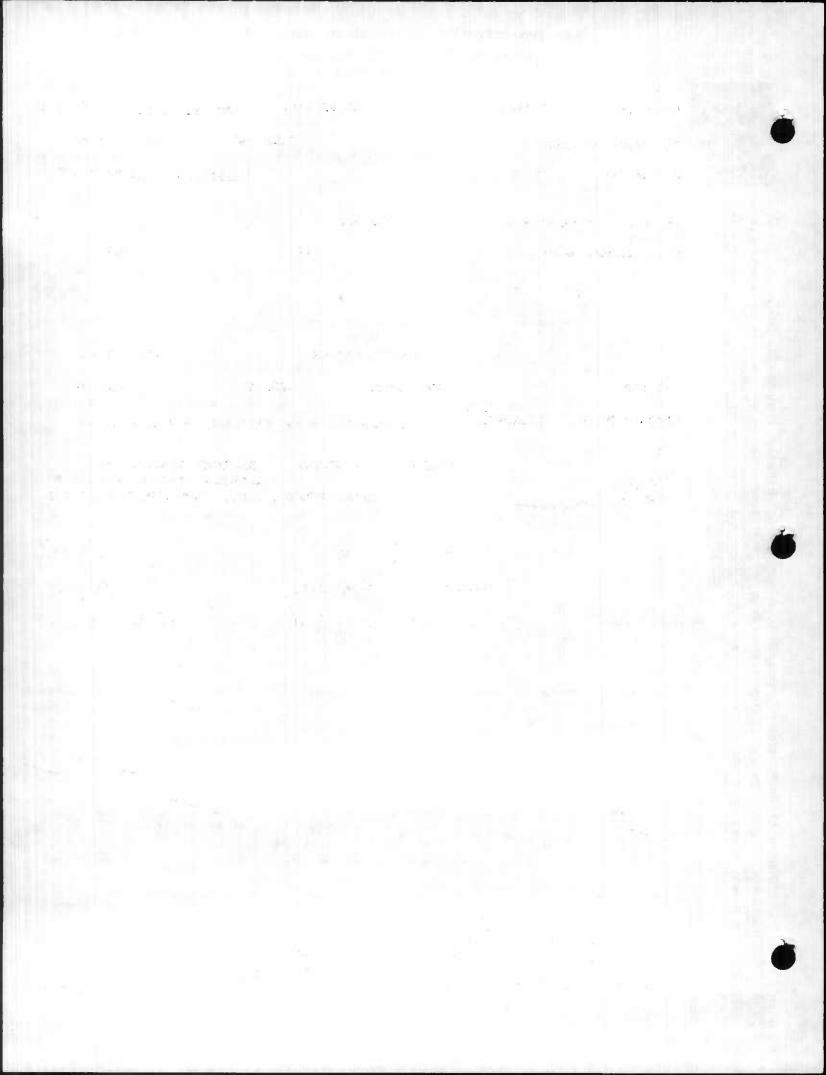
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:38 AM MAJEROWICZ FREDERICK MARCH 15, 1999 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PASADENA ANNE ARUNDEL 841 PASADENA ROAD If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1⊠M 2□ F Yrs. MARYLAND 61 216-36-1248 Director SEPT. 26, 1937 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo **PASADENA** MARYLAND ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 841 PASADENA ROAD 21122 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgln? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiena. Important if item 27 is marked other than "natural", or iter any injury or other traumatic swent, the Medical Examina 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL 4 owner/OPERATOR 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LILLIAN WILLIAM MAJEROWICZ SKLADAL 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (WIFE) CAROLYN DOROTHY MAJEROWICZ 841 PASADENA ROAD, PASADENA, MARYLAND 21122 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/18/99 DUNDALK, MD. HOLY ROSARY CEMETERY 22. Name and Address of Fedlity SINGLETON FUNERAL HOME, P.A., 21. Signature of Fuheral Service Licenses 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Danas 23a. Part T. Enter the disease, or on pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on 7 one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and tha bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760. Physician/Medical that initiated events resulting in death) Lest attanding p 88 23b. Did tobacco use contribute to the cause of death? by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 408 2 No 3 Probably 4 Unknown م signed b Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? should b 24a. Was an autopsy performed? Completed paga 2 has 1 Yes 2 No 1 Yes 2 No cartificata Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home STAesidence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Aftar or Attending 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: / 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide within 24 hours aftar To the Funeral Direcomplataly filled in b the Hospitai 29a. Certifier 1 Cortifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many@ stated. (Check only one) within 2 29c. License number 29d. Data sigged (Month, Dey, Year) 29b. Signature end title of confile 0 30. Name and address m 23a) (Type, Print) Elfott 31. Date filed (Month, Day, Year) Registrar's Signature State 1 7 1999 MAR Registrar

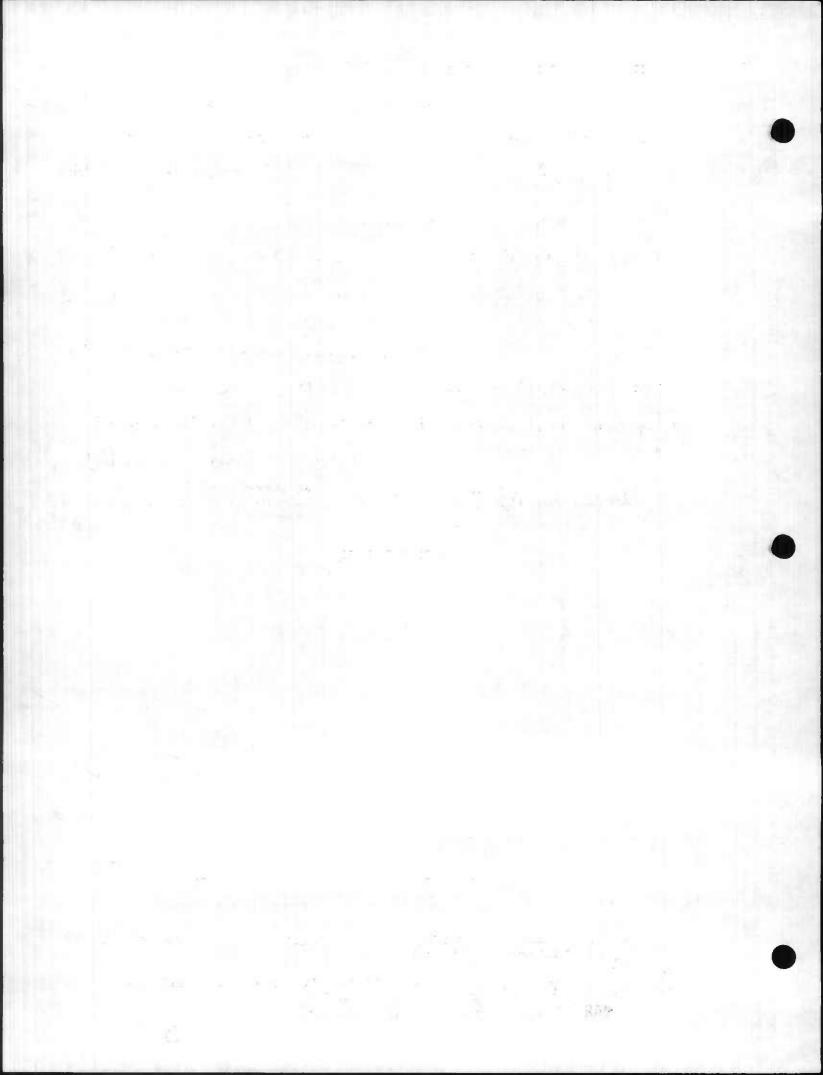
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State of Maryland / Department of Health and Mental Hygiene

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The law requires that the death certificate be executed

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Hospital

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P.O. Box 68760,

Records.

Division of Vital or Attanding Physician:

Maryland

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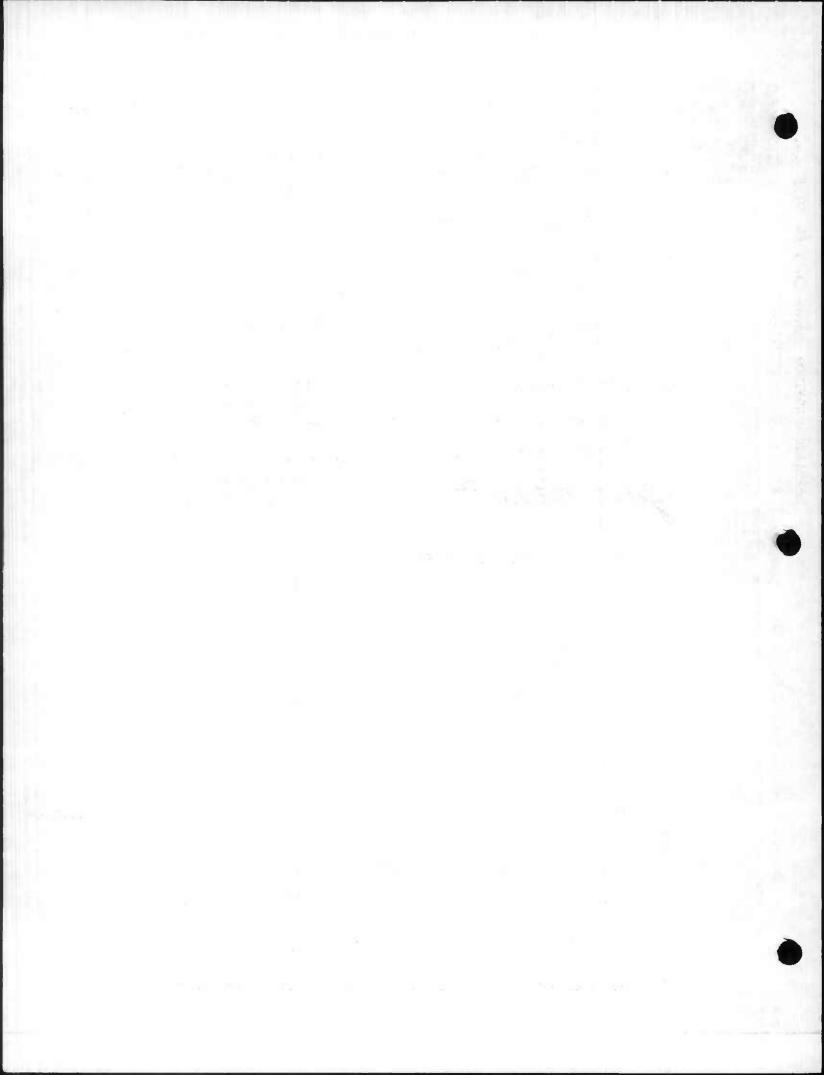
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Margaret Roxanna Mansfield 12, March 1999 9:55 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Daath 4c. County of Deeth Examiner Stella Maris Hospice Timonium Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Yaar) | 9. If Under 24 Hrs. | September 22,1918 5. Social Security Number 212-32-4302 9. Birthpiace (State or Foraign Country) 8 Maryland 7. Aga (In yrs. last birthdey) **Funeral** 1□M 2XF 80 Yrs. Director Usual Rasidance of Decadant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits traumatic evant, the Medical Examiner must be notified at Maryland Baltimore Timonium 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizan of Whet Country? 2300 Dulaney Valley Rd. 21093 United States Funeral 12. Was Dacedant Ever In U,S. Armed Forcas? 1 ☐ Yas 2 2 No If Yas, Giva Year or Detes: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2XX No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantery/Secondary (0-12) Collega (1-4or 5+) LPN nurse health care 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Peges 1 and 2 should be fill ment of Heelth and Mental Hant: if itam 27 is marked oth lury or othar traumatic evan Be Clifford Hay Mansfield Elizabeth Rice 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 4723 S. Gary Ave. Eloise M. Strozier/sister Tulsa, OK 74105-5337 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Dete permit. Peges Department of important: if it any injury or o 1 N Burial 2 □ Cramation 3 □ Removal from Stata 123/89 Baltimore, Maryland Lorraine Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvica Licanspe 22. Nama and Address of Fecility Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212 11. Entar tha disaasa, or complications that caused tha deeth. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, thock, or heert tellura. List only one cause on each lina. Approximata Intervel Between Onset end Death Physiclan /Medical Immediata Causa (Final disaasa or condition rasulting in daath) a BLADDER CANCER Examiner Dua to (or as e consequança ot): Examiner bunal-transit Sequentially list conditions, if eny, laading to Immediata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence ot): physician the burial Physician/Medical Dua to (or es e consequance of): USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24a. Was an autopsy performed? 24b. Wara autopsy tindings availabla prior to complation of cause of daath? page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No director, Be 25. Was casa ratarred to medical 26. Placa of Death (Check only ona) Hospital: Other: 4☐ Nursing Home 5☐ Residence 6 ②Other (Specify) Certification: To 1 ☐ Yas 2 🕱 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE funerel 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima ot 28d. Dascribe how injury occurred 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined within 24 hours efter dea To the Funeral Director completely filled in by th 3 Suicida Location (Street end Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 - Homicida edicai 1 Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted. 29a. Certifier (Check only one) 290. Signature and title of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year) Cal 30. Neme and address of person who completed causa ot death (Item 23e) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Data tilad (Month, Day, Yaar) 32 Registrar's Signatura State

Registrar **DHMH 16 Rev 6/95**

1 6 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Item: 29d per M.D G-769 3/30/99 reb Certificate of Death 1. Dacedant's Nama (First, Middle, Last) 2. Data of Daath . 1999 Month Joseph Leo Muth, Sr. March 14, 4:15 PM 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Timonium Stella Maris Hospice Baltimore 5. Social Sacurity Number 6. Sex 1 M 2 □ F If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) June 13, 1 Birthplaca (State or Foreign Country) 7. Aga (In yrs. lest birthday) Hours Days 219-18-7164 75 Yrs. 1923 Maryland Usual Residence of Decadent 10a Stata 10h County 10c. City, Town or Location 10d. Insida City Limits Maryland Baltimore Timonium 1 TYAS 2 NO NO 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 21093 2300 Dulaney Valley Rd. United States 12. Was Decadant Ever in U,S. Armed Forcas? 1 X Yas 2 ☐ No Wes Decedent of Hispenic Orlgln? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indien, Black, Whita, etc. 1 ☐ Navar Marriad 2 ☑ Married 1 ☐ Yas 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) salesman pharmaceutical 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Edward Sebastian Muth Regina Hibbitts 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 30 Dowling Cir. Baltimore, MD 21234 Joan Muth/wife 20b. Placa of Disposition (Neme of cemetery, cramatory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cramation 3 □ Ramoval from Stata 3/17/99 St. Mary's Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licensae 22. Name end Addrass of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 1. Entar tha disaase, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiec or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Intervel Batween Onsat and Deeth Immediate Causa (Final END STAGE DEMENTIA diseasa or condition resulting in death) Dua to (or as a consequence of): Dua to (or as a consaquance of): Dua to (or as e consequence of) Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death?

Physician /Medicai Examiner

attending physician and for use as the buriel-tren

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page 2 s certificate

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To the Hospital or Attending Pt within 24 hours effer death.
To the Funeral Director: After it completely filled in by the funera

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Completed

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The law requires that the death certificete be axecuted

Box 68760.

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Records,

Division of Vital

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Baltimore, Maryland 21215-0020

3/14/

Joseph MUth

Examiner Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disaasa or injury Physician/Medicai that initiated avants rasulting in daath) Lest

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown

24a. Was an autopsy performed? 1 Yas 2 No 24b. Wara autopsy findings available prior to complation of cause of death?

26. Placa of Death (Check only one) Othar: $_{4\,\square}$ Nursing Homa $_{5\,\square}$ Rasidanca $_{6\,\square}$ Othar (Specify) $_{1}$ HOSPICE

1 ☐ Yas 2 ☐ No

25. Was casa referred to medical axaminar? 1 Yas 2 No 27. Mannar of Death

5 Panding investigation

6 Could not be daterminad

28a. Date of Injury (Month, Dey Year)

Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify)

28c. Injury et Work? 1 ☐ Yas 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one)

1 X Natural

2 Accident

3 ☐ Suicida

4 Homicida

1 Madical Examiner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year) 3/15/99

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

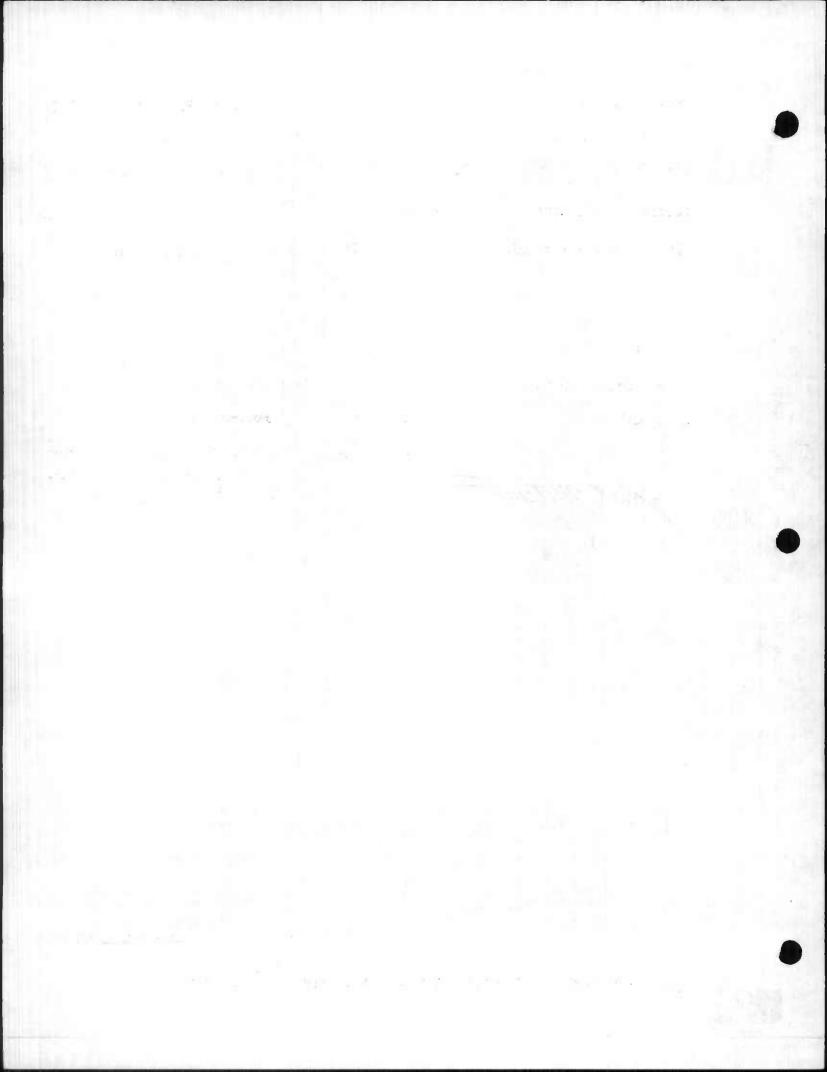
DR. TARIQ MAHMOOD 31. Data filed (Month, Day, Year) MAR 1 6 1999

32. Registrar's Signatura

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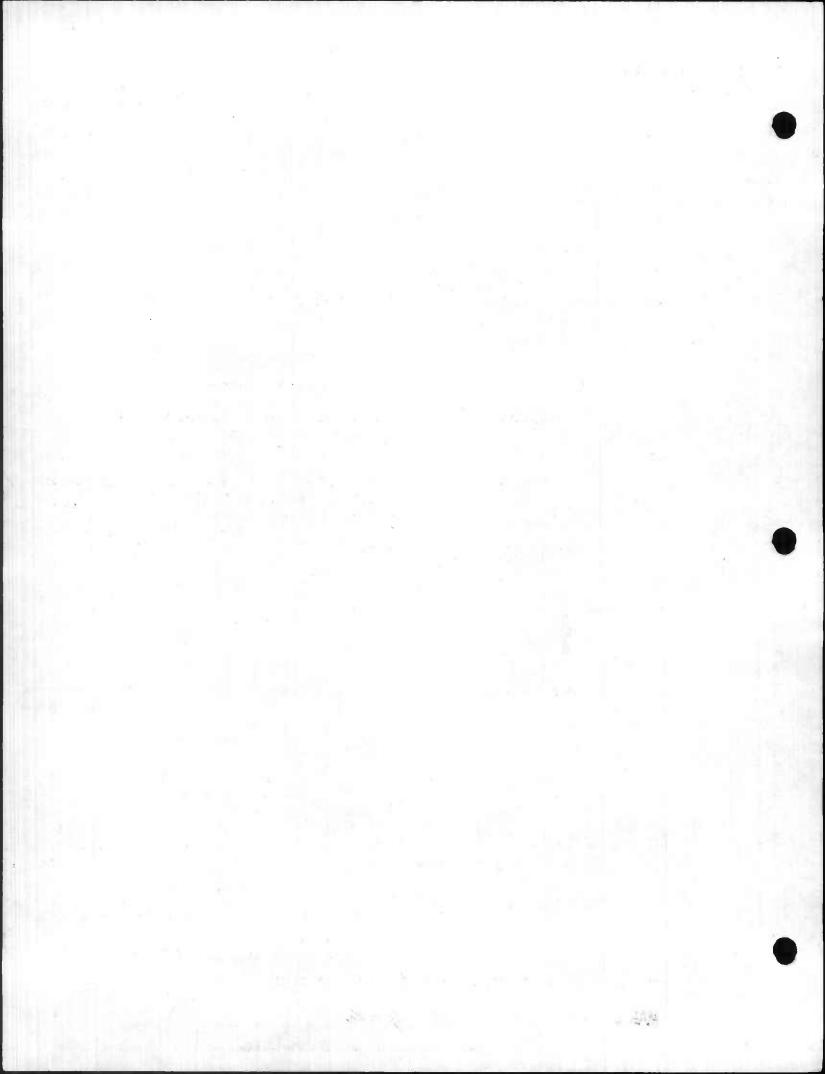
State Registrar

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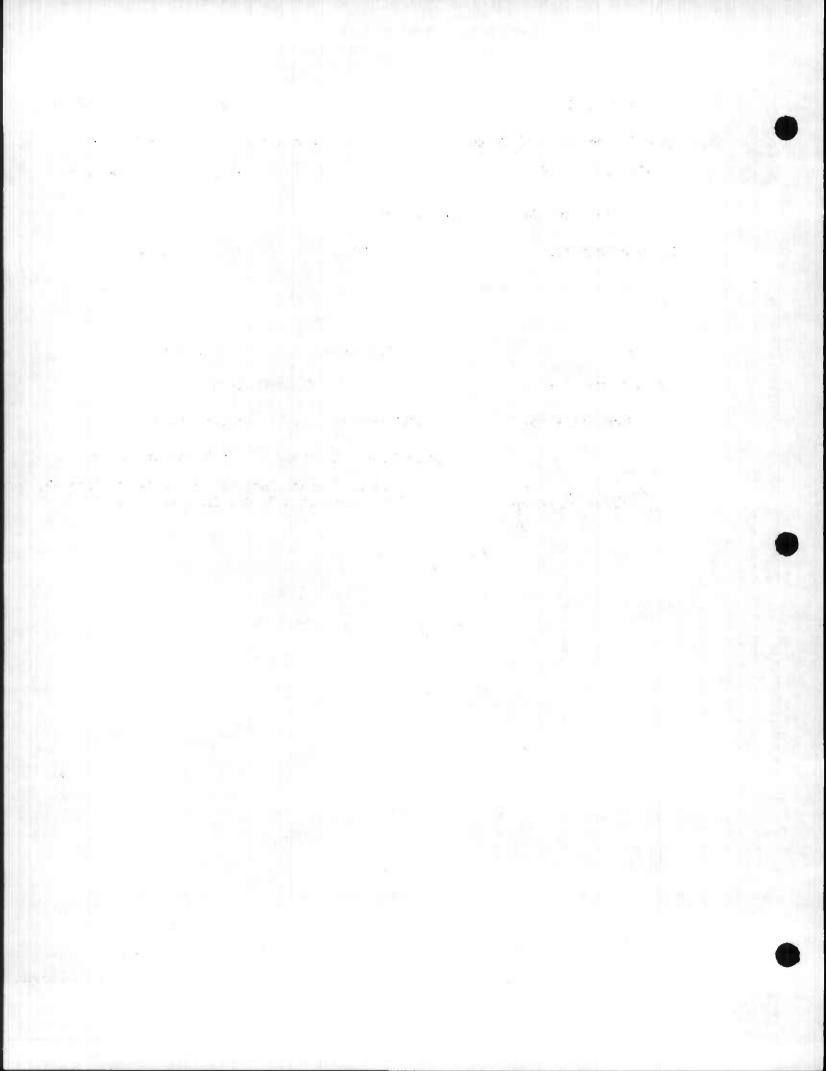
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/Medica Examine	An English Name of the at the attention of the attent and a surface the state of th			4b. City, Town, or Lo Port Depo	cation of Death	4c. County of De Cecil						
Funeral Director	213-38-9496 ¹ ♥ ^M 2□ F	(In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. 8. Dete of Birth 9. Birthplaca (State of Country) Nov. 15, 1941 Maryland			Birthplaca (State or Foreign Country) Maryland					
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Serfe	Maryland Cecil	Port Depo					1 ☐ Yes 2 ☐No					
h with th	10e. Street and Number One Central Drive		10f. Zip Code 21904			U.S.A.	Country? .					
vithin 72 hours after death with the Maryland ene. than "natural", or fterms 23s or 28s-f show the Marical Examiner must be notified at	11. Merital Status 12. Wes Decedent E Armed Forces? 1 Never Merried 2 Memled 1 Pes 2 No. If Yes, Give 3 Widowed 4 Divorced 1 Yes or Detes:	0	Wes Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☐ No	lispanto Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, atc.)	14. Race - Ar Bleck, W Specify: W						
DBIKIMOTE, Maryland Z1Z15-UUZU permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mentel Hygiene. Important: if tem 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Mexical Examples must be profited at page.	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+	(Give	dent's Usuel Occup kind of work done DO NOT use retired	petion during most of work d)	ost of working		ss/Industry					
The Hand	17. Father's Neme (First, Middle, Last)	1,02		18. Mother's Neme	(First, Middle,							
Viand ould be fit Mentel H arked oth	William Paul McGuigan			Mae Halb	aurner							
Mair and 2 sho sith and 27 is mar traumar traumar	19e. Informent's Neme/Relationship (Type, Print) Judith A. McGuigan/wife											
Peges 1 and of Heal of	20e. Method of Disposition 1	20b. Plece of Disposemetery, crem	b. Place of Disposition (Name of cemetery, crematory or other place)				or Town, Stete					
Dealth Departm Imports any Inju	21. Signature of Funeral Service Licensee Wade Di	21. Signature of Funeral Service Ucensee Wade Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Pert. Enter the disaasa for complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate Interval Between										
by the attending physician and deteched for use as the burial-transit	Immediate Cause (Finel disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events rasulting in deeth) Last	Due to (or es a conseque to (o	uance of):				Onset and Death					
certifice nding ph use as th												
at the deeth certification of the attending leteched for use a	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause giv	ven in Pert I.	23b. Did tobacco use contribute to the cause of							
es that the igned by the be deteched					101	/es 2□ No 3□	Probably 4 Unknown					
ew requir			80		24a. Was a perfor	an autopsy med?	b. Were autopsy findings aveilable prior to completion of cause of death?					
The The page					1 U Y	es 2 No	1 ☐ Yes 2 No					
Physician: The this certificate ral director, pag	25. Was case referred to medical axaminar?		Ott	28. Piece of Deet	n (Check only o	ne)						
Ing Physical differential diffe		28b. Time of	28c. Inju	4 Nursing Ho	-	enca 8 Other (S ow Injury occurred	pecify)					
To the Hospital or Attending P Within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Madical Cariffication:	3 Suicida 4 Homicide 6 Could not be determined 28e. Pleca of Injurbuilding, etc.	ry - At home, ferm, stri (Specify)	set, fectory, office		28f. Location (5 City or Tow		Rural Route Number,					
To the Hospital or within 24 hours after for the Funeral Dir completely filled in	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.											
To the comp	29b. Signature and title of certifier		29c. Licens	5653	2	29d. Date signed (Me	onth, Dey, Year)					
	30. Nema and address of person who completed cause of demands that Hosford-Skapof MD 111 W.					MINA	7 -1					
State	31. Data filed (Month, Day, Year) 32. Registrar		/ LINCOII, M	U. C17C1								
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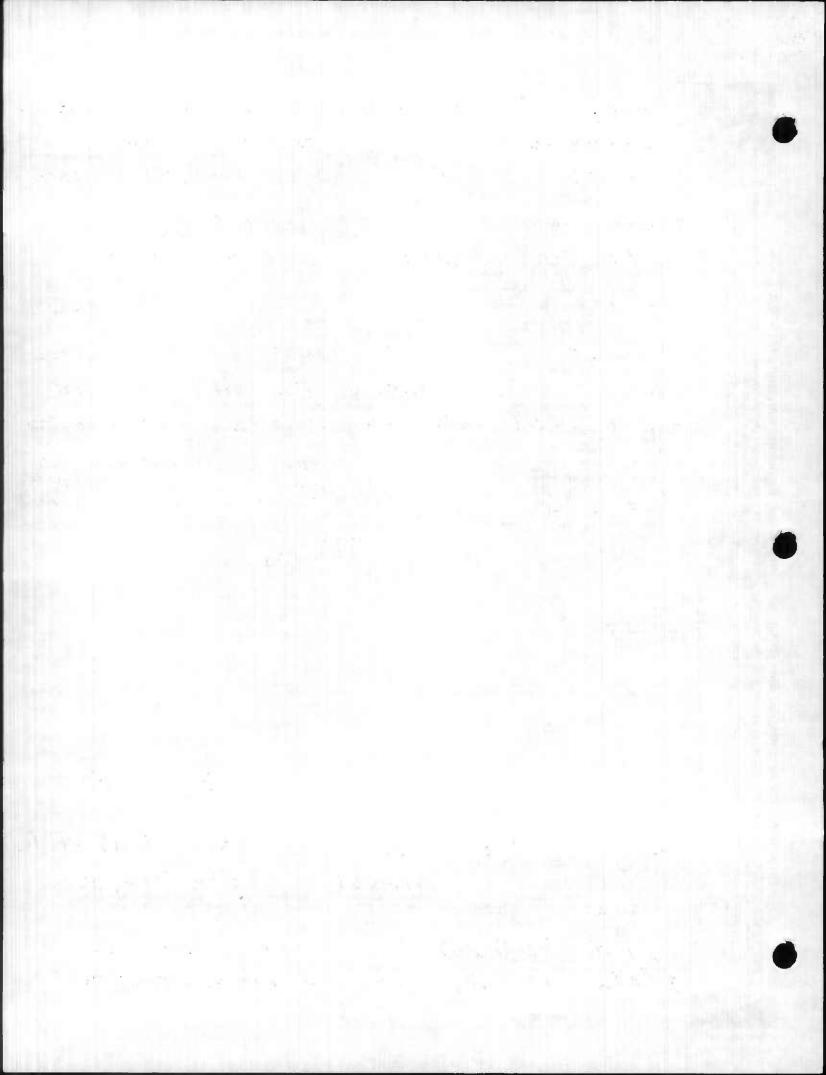
State of Maryland / Department of Health and Mental Hygiene Q Q Q 1. C

						,	Ce	rtificate d	of Death		Reg. No.) (00040		
			1. Decedent's Nam	a (First, Middle, i	Last)					2. Date of De Month	ath Day	Year	3. Time of Death		
	Physici '/Medic		Flora	Mongelli						March		1999	13:16		
Š.	Examin		4a Facility Nama (If not institution, g	giva street end numbe	er)			4b. City, Town, o	r Location of Deat	4c. Coun	nty of Death	1		
			Anne Ar	undel Me	dical Cent	ter			Annapo]	lis		Arun	del		
	Funeral		5. Social Sacurity !		. Sex 7.	Age (In yrs.	lest birthday)	If Under 1 You	ear If Under 24 H	rs. 8. Date of Bir	th y, Year)	9. Birth	nplaca (Stata or Foraign untry)		
	Director		065-07-		1 M 2 F	85	Yrs.				, 1913		w York		
	pur		Usual Rasidence of	f Dacedant 10b. County		10c City	y, Town or Le	neation					10d. Inside City Limits		
	sho sho	2	MD	Anne Ar	undel		rna Pa						1)∑ Yes 2□No		
	28a-f	Director	10e. Street and Nu		Onder	00 00	IIIG 7	10f. Zip Coo	60		10g. Citizen of What Country?				
	With the second			field Rd				21140			US/		and y r		
	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hygiena. It is marked other than "natural", or items 23a or 28a-f show traumate event, its Maritesi Examines must be notified at	Funeral		TTGTU NO	12. Was Decede	nt Ever in II	C 13						ican indian.		
	Herr Press	5	11. Marital Status	ried 2 ☐ Married	Armed Force	is?		If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) Black, White, etc.					e, etc.		
20	rs aff	by F	3 ☑ Widowed		If Yes, Give	•		1□Yes 2□X	No Specify:		Spec	oify: Whi	te		
Š	hou	8	X	15. Decedent's			16a. Dece	dent's Usual Oc	ccupation		16b. Kind of	Businass/I	ndustry		
21215-0020	nin 72	Completed		cify only highast	grede completed) Collage (1-4)	or 5 ()	(Give	 Decedent's Usual Occupation (Give kind of work dona during most of working) life. DO NOT use ratired) 			ting				
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b	of tiled will Hygien other th	Bec	17. Father's Name	(First, Middla, La	st)				18. Mother's N	ame (First, Middle	, Maiden Surne	ame)			
Maryland	Aenta Aenta rked ric e	O	Victor	Montagn	ıa				Maria Panzardi						
and	should and Men americ urnetic		19a. Informant's N	ame/Ralationship	(Type, Print)		19b. Mail	ing Address (St	reet and Number or	Rurel Route Numb	er, City or Tow	m, Stata, Z	ip Code)		
	Health a tem 27 le		Roy Mo	ngelli -	son				ll Ct., Ar	nnapolis,	MD 2:	1401			
more,	of He day		20a. Method of Dis			20b. P	Placa of Disponentery, cre	osition (Neme of matory or other	f plece)	Date	20c. Location	n - City or T	Town, State		
Ĕ	mit. pertm y inju		1 Libural 2 Cremation 3 Hemovaltrom State										New York		
a			21. Signature of Paneral Sarvice Licenter 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP,												
n			1/1/2	mas Il	Y	_	G	ary L. I	Kaufman Fu	uneral Ho	ome @ M	eadow	-		
			23a. Part 1. Enter	the disaasa, or co	implication that causely one acide	sed the deat	h. Do not an	tar tha mode of	dying, such as cerd	LVO., EIK	rest,	Ma.	21075 Approximate		
	Physician		shock, or had	art fallura. List on	ly ona on each	n line.							Interval Between Onset and Death		
	/Medical		Immediate Cause	(Final		Becal	2	has the	10			1			
	Examiner	Immediate Cause (Final disease or condition rasulting In death) a.											0.00		
	بحسب	ner			/	Δ Δ			there ?						
	The law requires that the death certificete be associted at has been signed by the attending physicien end page 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list co	b											
o,	en er urial-t	Ĭ.	Sequentially list co if any, leading to in causa. Enter Und Cause (Disease o	mmediate erlying		Com		andens	diser	e		i			
68760,	nysici	Ica	that initiated event resulting in death)	c			1								
	ng ph	5	rosaning in doutry	Cast		Como	20/100	He -	diser	lu					
P.O. Box	auth cer attendir for use	Physician/			d	1	751.00	11-7							
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J.	as that the dailigned by the a	Phy	0							10	Yes 2MN	3 Pr	robably 4 Unknown		
	gned be de	by	Thei	i morti a						_					
Records,	v require been signal	ted	4-1=	- m	bonson						an autopsy ormad?	8	Wara autopsy findings available prior to		
ecc	has be	ple	11-1-0	7 7	Jyncoy!	9				- 1			completion of cause of death?		
	The I	Completed								10	Yes 2 No	1	I □ Yes 2 No		
m	en: rtifica	Be	25. Was case refe	rred to medical					26. Place of D	Death (Check only	ona)				
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0	g Ph	ü	27. Mannar of Dea		28a. Data of I (Month,	njury Dev Year)	28b. Time of	of 28c.	Injury at Work?	28d. Dascribe	how injury occ	curred			
0	Attanding or death.	atic	1 ☑ Natural 2 ☐ Accidant	5 Pending investigat	tion				1 ☐ Yes 2 ☐ No						
Division of Vital	er de	tific	3 ☐ Suicide 4 ☐ Homlcide	6 Could no determine	ad 288. Place of	Injury - At he	oma, farm, si	reet, factory, of	fice		(Streat and Numer, State)	mber or Ru	ıral Routa Number,		
<u> </u>	tal or A	Certification:				()	,,								
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	he H		one)		and manner	stated.									
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Σ	29b. Signature and	d title of certifier					censa number		29d. Date sig				
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	4		30. Nama and add	rass of person wh	no complated causa o	of death (Iten	n 23a) (Type	, Print)			. 1	1			
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теу	Mason			Otato or i	viai yiaila / i	Certifica			wichtai i iy	Reg. No.		
			1. Decedani's Nama (First, Middla, L	ast)		1			2. Data of D	eeth	1200	3. Time of Death
	Physici		COREV	JAM	AR	MAS	ON		Month	Day 10, 1999	Year	1:00 P.M.
	/Medic Examir		4e Fecility Neme (If not/institution, g			, , , , ,		4b. City, Town, or		-		1100 1111
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	Funeral			Sax 7.	Age (In yrs. last bi		ar 1 Yaar	If Undar 24 Hrs	8. Data of Bi			placa (Stata or Foreign
	Director		219-96-3706	1,13 M 2□ F	17	Yrs. Months	Days	Hours Min.	JUNE	18,1981	MA	RYLAND
٠.	D		Usual Rasidenca of Decedant								/	
	how		10a. Stata 10b. County		10c. City, Tow	n or Location	2		0		1	Od. Inside City Limits
	the Marylan 28a-f show	cto	MARYLAND /	VA				TIMOR	ECI	TY		1K Yes 2 No
	4 2 2	Dire	10e. Street end Number				ip Coda			10g. Citizan of	What Cour	ntry?
	23a	a	109 N. EL	LWOOD				212	24	u	SA	
	er de	Funeral Director	11. Merital Status	12. Was Daceda Armed Forca	s?	13. Was Dec	edant of H ecity Cuba	lispanic Origin? (S an, Mexican, Puar	Specify Yes or N to Rican, atc.)	o- 14. Rac Ble	ck, Whita,	can Indien, atc.
20	or i	by F	1 Naver Marriad 2 Married 3 Widowed 4 Divorced	If Yas, Giva		1 ☐ Yes	2 NO	Specify:		Specify	Y: 12 ,	n // 1/
8	be filed within 72 hours efter death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examinet must be notified at			Yaar or Data		. Decedant's Us	ual Occur	estion		16b. Kind of B	VO L	HCK
15	n 72	Be Completed	15. Decedant's (Specify only highast g	rada complated)		(Giva kind of w	rork dona	during most of wo	rking	Too. Kind of B	uon igodi ii	addity
12	filed withir Hygiene. ther then	E	Elementery/Secondery (0-12)	Collega (1-4c	or 5+)		IDE			HIG	45	CHOOL
D	Hyg Hyg ther	Ö	17. Fathar's Nama (First, Middla, Las	st)		010			ma (First, Middle	a, Maidan Sumen		CHOOL
lan	id be ental ked c	ToB	VERNON	F	M	ASON		ARN	ITA	PH	-111	1185
ary	Baltimore, Maryland 21215-0020 pormit. Pages 1 and 2 should be filed within 72 hours eft Depertment of Hauth and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Modical Examples.	-	19a. Informant's Name/Ralationship	(Type, Print)	198	o. Mailing Addre	ss (Street	and Number or R				
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re,	f Had itsm		20a. Method of Disposition		20b. Placa	of Disposition (Nary, cramatory or			Data	20c. Location	City or To	
E	Page anto nt: If i		1X Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec		MT -	21011	7- 01	-TEOIL	12-17-99	1 00/5	0011	NE, MO.
altimore,	permit. Pages Depertment of Important: If it any injury or o		21. Signeture of Funeral Sarvice Lic			22. Nama	and Addra	ss of Facility	0 - 1 - 1	TO E	11000	PAL HOME
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			23a. Part1. Entar tha disaasa, or co	mplications that caus	sad tha daath. Do	not antar tha me	oda of dyir	ng, such as cardla	c or raspiratory	arrasi,	TORE	MD. 212/7 Approximata
4	Physician		shock, or heart failure. List on	y ona causa on each	n line.	-						Interval Between Onset and Death
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P.O.	the da	ysic	Pert II. Other algnificant conditions	contributing to death	but not rasulting	in tha undarlying	causa giv	ven in Part I.	23b. Dla	Ac	entribute t	o the cause of death?
9	that the by data	표							10	Yes 2/2/No	3 □ Pro	bably 4 Unknown
Division of Vital Records,	The law requires that the daath cer ete has been signed by the attandin page 2 should be datached for use	Medical Certification: To Be Completed by Physician/M							24a We	s en autopsy	24b. W	ara autopsy findings
0	redin	ete							per	formed?	ev ev	relieble prior to empletion of cause
36	has ge 2	d L							N.	,		daath?
ai	: The	ပ္ပ							X	Yas 2□No	1	Yas 2 No
VII.	hysician: The la his certificete has il director, page 2	Be	25. Was casa rafarred to medical axaminar?	Hospital:			Oth	or:	ath (Check only			
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Sic	death death stor:	Ical	3 Suicide 6 Could not	be con Blace of	Injury - At home, f	70		7	28f. Location	(Street and Num	ber or Run	al Route Number
≥i	Or A Direction	erti	4 ☐ HomicIda determine	building,	atc. (Specify)	77/ 15	Jry, omce		City of T	own, State)	-	Ho o
_	pital ours eral filled	Ö	29a. Certifier 1☐ Certifying F	Physician: To the be	st of my knowledn	e deeth occurre	d at the tir	me deta end plac	and due to the	e cause(s) and m	ennelas	stated
	Hos 24 h Fun etely	dica		aminer: On the basis end mannar	of exemination as							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director,	Me	29b. Signeture and titla of cartifiar	1		2	9c. Licans	sa number		29d. Dete signa	ad (Month,	Day, Year)
5	- s - ō		1// 1/10-	Los	1110			O.C.M.E		March 1	1. 10	99
	2		30. Nama and address of person wh	o completed causa of	death (tem 02-)	(Type Drine)		O.C.II.E	•	LICECT J.	., 1.7	
	1		30. Nama and address of person wh	CALLE A			Stre	eet, Bal	timore.	Marylan	1 212	201
	Sta	ite	31. Data filed (Month, Day, Year)	32. Regi	strar's Signature		-			2		
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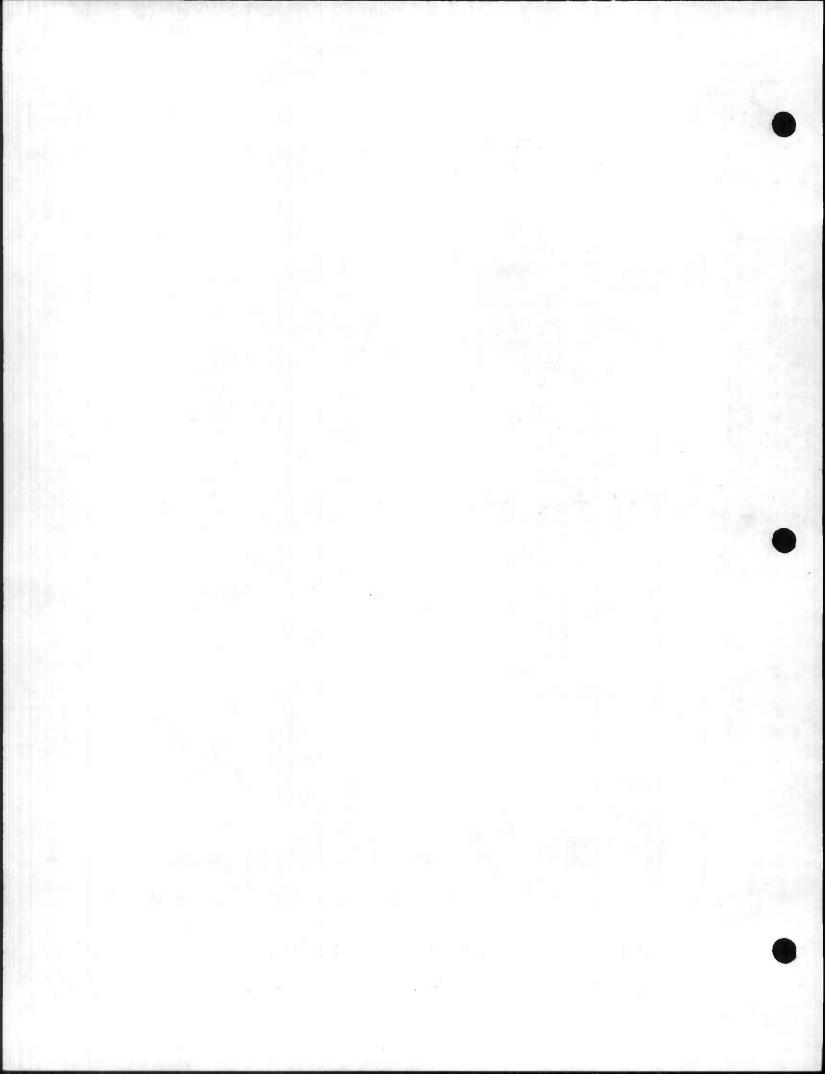


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Physician 15, 1999 4c. County of Deeth Josephine Michael S

4a Facility Name (If not institution, give street and number) March /Medical 4b. City, Town, or Location of Death Examiner Columbia Howard County General Hospital Howard If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Data of Birth (Month, Dey, Year) Birthplace (Stata or Foreign Country) Funeral Days 10 M 20 F 158-12-9670 Sept 16, 1916 Director New Jersev Usual Residence of Decedent with the Maryland 10a. Stata 10c. City. Town or Location 10b. County 10d. Insida City Limits "natural", or flams 23a or 28a-f show adical Examiner must be notified at 1 Yas 2 No MD Howard Director Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4964 Woodward Gardens 21044 USA Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ঐ No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiens. Important: if flem 27 is marked other than "natural", or herr any injury or other treumstic event, the Medical species and any injury or other treumstic event, the Medical services. Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Sepondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) Martin Martignetti Rose Cursio 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Linda M. Ryan (Daughter) 4964 Woodward Gardens, Columbia, MD 21044 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/18/99 East Hanover, NJ 4 □ Donation 5 □ Other (Specify) Gate of Heaven 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses Robert Buch 5555 Twin Knolls Road, Columbia, MD 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical WELR Examiner Physician/Medical Examiner physicien end the burlal-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of) P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2QNo 3 Probably 4 Unknown Division of VItal Records, p 24b. Were autopsy findings evailable prior to completion of cause of deeth? Be Completed 24a. Was en eutopsy 1 ☐ Yas 2 ☐ No 1 Yas 2 Mg this certificata al or Attending Physician: The safer deeth.
In Director: After this certificate of in by the funeral director, pa 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 4 28c. Injury at Work? 27. Manner of Deat 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 Yas 2 No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Redical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) William 30. Name and address of person who compl leted cause of death (Item 23a) (Type, Print) 1055 FIOW mi Well 31. Data filed (Mog 32/Registrar's Signatura State Registrar



Please

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	State of Maryland / Department of Health and	d Mental Hygiene	9 1	831.9
	Certificate of Death	Reg. No.		
st)	A 4	2. Date of Deeth Month Dev	Year	3. Time of Dee

Phys /Me Exan

Funer Directo

permit. Pages 1 end 2 should be flied within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, its Medical Examinal must be notified at

Baltimore, Maryland 21215-0020

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burliet-trensit Division of Vital Records, P.O. Box 68760,

> 0 State Registrar

30 Name end eddress/of person who completed cause of deeth (Item 23a) (Type, Print)

5601

32. Registrer's Signature

AYMAN KOTEISH
31. Dete filed (Month, Day, Year)

MAR 1 7 1999

		Cert	iticate of	Death	Reg	. No.		
an	Decedent's Name (First, Middle, Last)	A 4			2. Date of Deeth Month	Dey	Year	3. Time of Deeth
all	DORIS M.	MONV	IINGS		MARCH	12 19	999	9125 AN
er	4a. Fecility Name (If not institution, give street and number)			4b. City, Town, or L		4c. County of	of Deeth	7.1.
	GOOD SAMARITAN H	OSPITAL		BALTIA	MORE	N/A		
	5. Social Security Number 6. Sex 7. Age (III	n yrs. lest birthdey)	If Under 1 Yea	r If Under 24 Hrs.	8. Date of Birth (Month, Dey,)	(222)	9. Birthple	ace (State or Foreign
	212-34-5942 1□ M 2対 F 62	Yrs.	Months Deys	Hours Min.	Aug. 20,	1936	Mar	yland
	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Loca	ation				10	d. Inside City Limits
Stor	Maryland N/A	Bal	timore					1 Yes 2 No
Funeral Director	10e. Street end Number		10f. Zip Code		109	g. Citizen of W	hat Count	y?
8	4125 Shannon Drive		21	213		u. s.	A.	
Jer	11. Maritel Status 12. Was Decedent Eve	r in U,S. 13. W		Hispenic Orlgin? (Sp ban, Mexican, Puerto	ecity Yes or No-	14. Race	- America	
by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Yesr or Dates:		Yes, specify Cul ☐ Yes 2 No		Rican, etc.)	Specify:	white, e	
Completed	15. Decedent's Education	16a. Decede	nt's Usual Occu	pation		Sb. Kind of Bus	siness/indu	ıstry
	(Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+)	(Give ki	nd of work done NOT use retir	e during most of worked)	king			,
E	Elementery/Secondary (0-12) College (1-4or 5+)	Bo	okkeepe	on.		Real E	state	,
De C	17. Fether's Name (First, Middle, Last)		01010000		ne (First, Middle, Me			
00	Louis D'Ascenzo			Stella	Popko			
-	19a. informent's Name/Reletionship (Type, Print)	19h Mailing	Address (Street	et end Number or Rui		City or Town	State Zin (Code)
								ŕ
	John E. Munnings (Husband) 20e. Method of Disposition	20b. Place of Disposi		Drive, Ba		oc. Location - 0		
	1 ☐ Burlal 2 🛱 Cremation 3 ☐ Removal from State	cemetery, creme	tory or other pl	,				
	4 □ Donation 5 □ Other (Specify)	Green Mour	it Crem	atory 3	3/17/99 B	altimor	ie, M	aryland
	21. Signature of Funeral Service Licensee	22. 1	Name and Add	ess of Fecility Funeral	Hama Tua			
	Buran Celvellon			ims Lane,			Pand	01012
7	23e. Pert1. Enter the diseese, or complications that caused the	death. Do not enter	the mode of dy	ring, such es cardiac	or respiretory erres	it,		Approximete
	shock, or heart feilure. List only one ceuse on each line.							nterval Between Onset end Death
	Immediate Cause (Final							4
	Immediate Cause (Final disease or condition resulting in death)			ORDME				DAY
5		to (or es e conseque	2010.1					
	b. LIVER	DAT CE	2	ANCEK				MONTHS
Examiner	Sequentially list conditions, Due if any, leading to immediate	to (or as a conseque	ence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury						i	
چ		to (or as e conseque	ence of):				i	
n wealcal	d							
completed by ruysiciar	Part II. Other eignificant conditions contributing to death but no	ot resulting in the und	erlying cause o	iven in Part I	23h Did tob	acco liee con	tribute to	the cause of death?
11 ye	^			SIT III F GILL.			3 Probe	1/
	CHROMIC OBSTRUCTIVE PULL	IONARY D	ISEASE		10.70	20110	3 Probe	ibiy 40 Olikilow
2					24a. Wes an	autopsy	24b. Wer	e eutopsy findings
					performe		com	leble prior to pletion of cause
7							of de	eath?
					1 X Yes	2□ No	1 🗆	Yes 2 No
2	25. Was case referred to medical examiner?				th (Check only one)			
	1 ☐ Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpetient	3LI DOA		ome 5 Residen	ce 6 Othe	r (Specify)	
	27. Menner of Deeth 1 Natural 5 Pending 2 Accident investigation	28b. Time of Injury	M 1	ury et ork?] Yes 2 No	28d. Describe how	Injury occurre	d	
edical certification:	3 Suicide 6 Could not be determined 28e. Piece of Injury building, etc. ⟨S	At home, ferm, stree pecify)	t, fectory, office		28f. Location (Stre City or Town,		r or Rurel	Route Number,
1 100	29a. Certifier 12 Certifying Physician: To the best of my (Check only 2 Medical Examiner: On the basis of exe	y knowledge, death o	occurred at the t	ime, date end plece,	end due to the cau	se(s) end men	ner es ste	ted.
5	(Check only 2 Medical Examiner: On the basis of exe and menner stated.	mination and/or inve	stigation, in my	opinion, death occur	red et the time, dat	e end place, ar	nd due to t	he cause(s)
	29b. Signature and title of certifier		29c. Licen	ise number	290	d. Date signed	(Month, D	ey, Year)
	Myman Kateish	MD	10	10581	M	ARCH	12	1999
								* *

LOCH RAVEN BLVD

- BALTIMORE

MD

21239

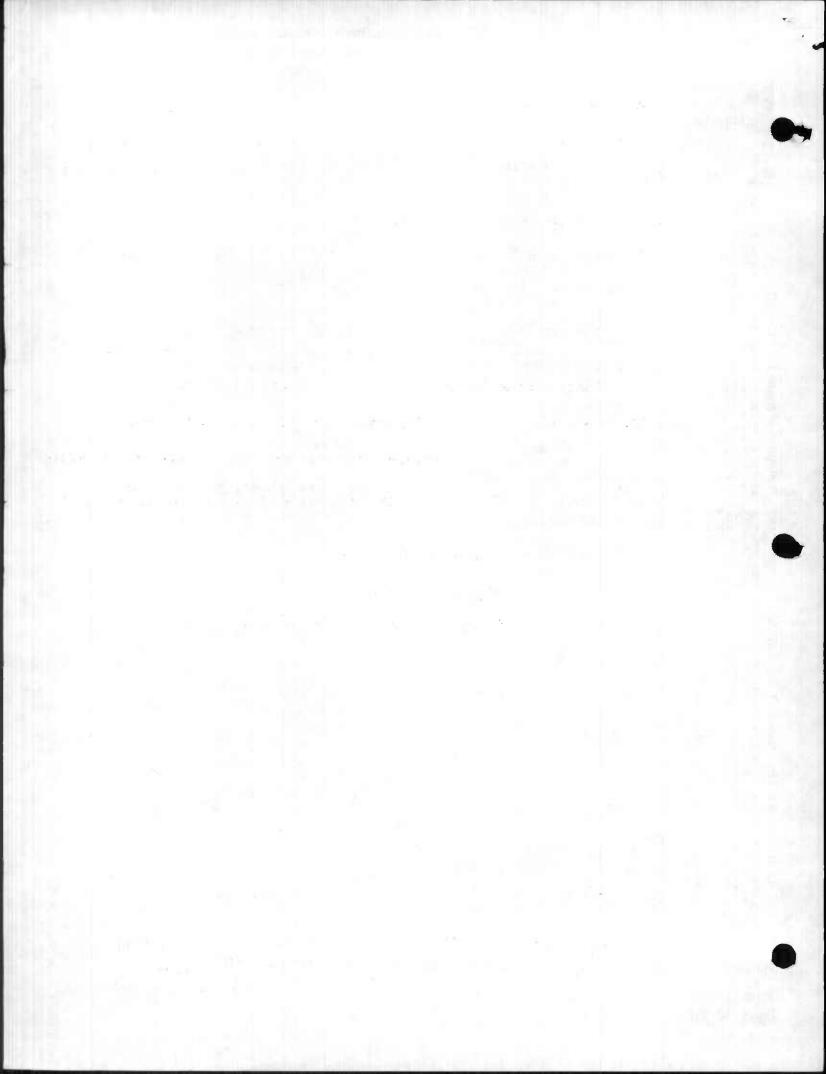


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State of Maryland / Department of Health and Mental Hygiene 9

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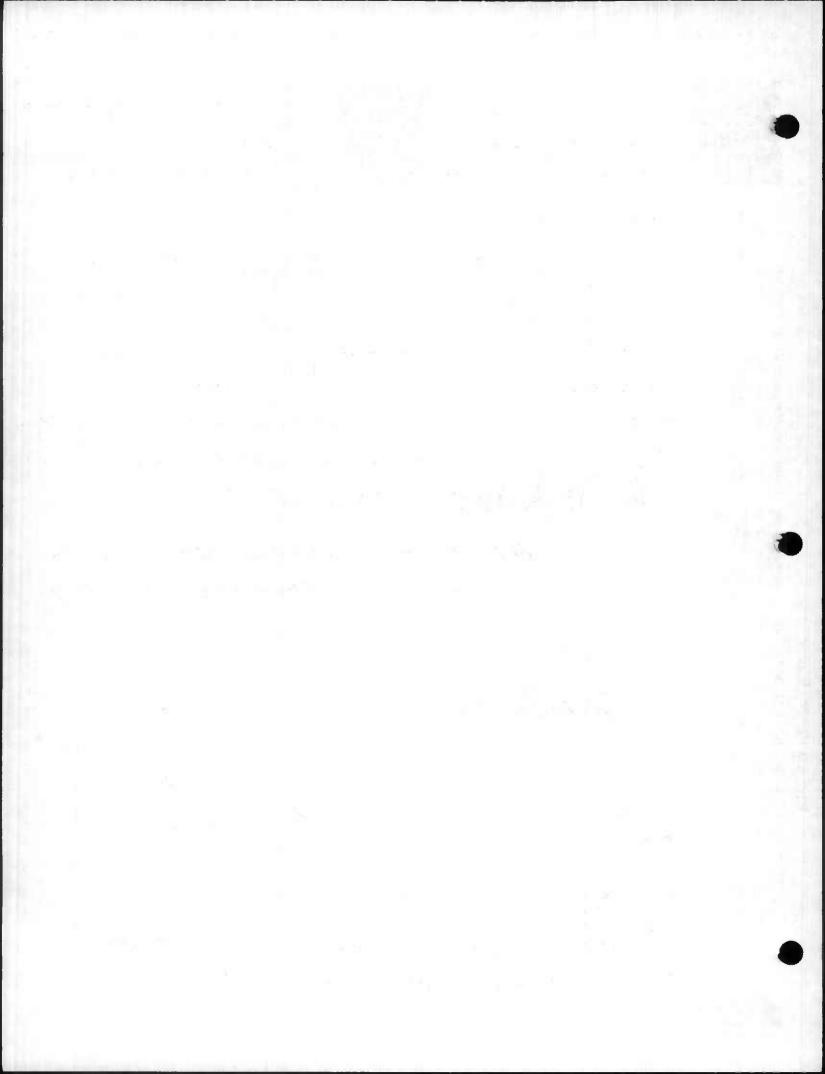
Catherine Ans	tino Nino								
4e Facility Nema (If not institution, g	CTHE MINS	gard				Month	13, 19	Yaar 199	10:30 AM
	ive street and number	r)			4b. City, Town, or				1 20100 120
715 Howard Roa	d				Pikesvil	1e	Ba1	timo	re
	Sex 7. A	ige (In yrs. la:		Undar 1 Yaar	If Undar 24 Hrs	8. Data of Birt			laca (State or Foreign
213-38-6822 Usual Rasidance of Decedant	1□M 2XF	85	Yrs. Mc	nths Days	Hours Min.	Dec. 26	, 1913		yland
10a. Stata 10b. County		10c. City,	Town or Locatio	n				1	0d. Insida City Limits
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	and		10		10				itry?
		t Evar in U,S	. 13. Was			Specify Yes or No-			ean Indien,
1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☒ If Yas, Give	No				to Rican, atc.)			atc. Nhite
15. Decedant's	Education		18a. Decedant's	Usual Occu	pation	dia	16b. Kind of B		
Elamantary/Secondary (0-12)	Collaga (1-4or	5+)				rking			
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		ard			2.15				
			19b. Mailing Ad	Idrass (Stree				Stata, Zip	Code)
Mr. Edward Ninga	rd		715 How	ard Ro	oad Pike	sville,	MD 212	208	
20a. Mathod of Disposition		20b. Pla	ca of Disposition	(Neme of	ece)	Date	20c. Location -	City or To	own, State
		Bl				3/17	Woodla	wn, M	aryland
21. Signature of Funeral Service Lie	ansee Lor	Ken	Lor	ing By	ers Funer				21133
Immediata Causa (Final disaasa or condition rasulting in death)		Dua to (or a	as a consequand	ea of):				-	Onset and Daath
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	~ ~	Due to (or e	es e consequand	a of):	6. 0.				
Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting In death) Last b. HyperInjedeana, Due to (or es e consequenca of): C. Ongamic Brann									
	d								
Part II. Other significant conditions	contributing to death I	but not rasult	ing in tha undarl	ying causa gi	ivan in Part I.	23b. Did 1	obacco usa co	ntribute to	o the cause of death
						10	Yes 2 No	3 Pro	bably 4 Unknow
								av	ara autopsy findings ailabla prior to implation of causa daeth?
						101	as 2 No		Yas 2 No
25. Was casa rafarrad to medical axaminar?						ath (Check only o	na)		
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1 Natural 5 □ Panding	(Month, De	ay Year)	Injury			280. Dascribe			
3 ☐ Suicida 6 ☐ Could not	be 28a. Placa of In	njury - At hom tc. (Specify)	a, farm, straat, f	actory, offica		28f. Location (S City or Tox	Street and Numi	ber or Rura	al Route Number,
(Check only 2 Medical Exa	hysician: To the best	t of my knowle	edga, daath occ	urred at tha ti	ima, data and place	e, and dua to tha	causa(s) and m	annar as s	tated.
one)	and mannar s	tated.							
Down		mo.							
30. Nama and address of person who	complated causa of	daath (Itam 2	3a) (Type, Print			conter.	19, Walk	erAre	2.
	Maryland Balti 10e. Street and Number 715 Howard R 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedant's (Specify only highest g Elamantary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last Henry 19a. Informant's Name/Relationship Mr. Edward Ninga 20a. Mathod of Disposition 1 Buriel 2 Crametion 3 4 Donation 5 Othar (Specify only highest g 21. Signature of Funeral Serve Less 23a. Part Enter the disease, or conshock, or heart failura. List only Immediate Causa (Final disease, or conshock, or heart failura. List only Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Causa (Disease or Injury that Initiated avants rasulting in death) Last Part II. Other significant conditions 25. Was casa referred to medical axaminar? 1 Yes 2 No 27. Mange of Death 2 Noticida 4 Hornicida Conditions 29a. Cartifiar (Check only one) 29b. Signatura and titla of cartifiar (Check only one) 29b. Signatura and titla of cartifiar (Check only one)	Maryland Baltimore 715 Howard Road 11. Marital Status 1	Maryland Baltimore 10e. Street and Number 715 Howard Road 11. Marital Status 1	Maryland Baltimore Pikesvil 10e. Street and Number 715 Howard Road 11. Marital Status 1	Maryland Baltimore Pikesville 10e. Street and Number	Maryland Baltimore Pikesville 10/. Zpc Cota 71.5 Howard Road 12 Was Decedent Ever in U.S. 13. Wes Decedent of Hisperic Origin (f. Ameel Forcer in U.S. 13. Wes Decedent of Hisperic Origin (f. Mercer Maried 28 Maried 3 Widewed 4 Divorced 14 Nas. Gave 14 Nas. Gave 14 Nas. Gave 14 Nas. Gave 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 16 Specify only highest grade completed 17 Specify only highest grade completed 18 Decedent's Used Occupation (Give British of Work doing dwing most of work for the dwing most of work for dwing most of work for dwing most of work for dwing for the form of	Maryland Baltimore Pikesville 100. Zip Code 21208 101. Zip Code 21208 11. Martial Status 12. Was Decedent Evar in U.S. Amed Forces? 11. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, Specify Cuben, Mascian, Puarlo Rican, atc.) 11. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, Specify Cuben, Mascian, Puarlo Rican, atc.) 11. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, Specify Cuben, Mascian, Puarlo Rican, atc.) 11. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, Specify Cuben, Mascian, Puarlo Rican, atc.) 11. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, Specify Cuben, Mascian, Puarlo Rican, atc.) 11. Was Zip No Specify 12. Was Zip No Spec	Maryland Battimore Pikesville 100, 2c code 100, Citizen of 1 100, Citizen of 1 100, Citizen of 1 100, Citizen of 1 100, Citizen of 1 100, Citizen of 1 100, Citizen of 1 110, Martial Status 10 New Mariad 28, Maria	Maryland Battimore Pikesville 10s. Street and Number 715 Howard Road 11. Maridal Status 11 Newer Mariadd 22D Mariadd 32D Ma



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State of Maryland / Department of Health and Mental Hygiene Q

			Cert	tificate of	Death	R	eg. No.	Li	0351
Physicia	an l	Decedent's Neme (First, Middle, Last)				2. Data of Dea Month		Year	3. Time of Death
/ /Medic		Georgia Eckert Piller				03	16 1	999	2.40Am
Examine	er	4e. Fecility Neme (If not institution, give street and number)			4b. City, Town, or L		4c. County		
		Mariner Health Care 5. Social Security Number 6. Sex 7. Age (In vrs. las		if Undar 1 Yea	Baltime r if Undar 24 Hrs.		Ba1	tim	
Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. las 1 □ M 2 ☑ F 8 3 8 3	Yrs.	Months Days	Hours Min.	8. Data of Birth (Month, Dey 10/14/	Year)		plece (Steta or Foreign htry) Yland
dand	ı		Town or Loca	ation				1	Od. Inside Ctty Limits
with the Maryland ta or 28a-f show	Director	Maryland Howard Jes	ssup	101 75- 0-4-		1.	00		1 ☐ Yes XIXNo
death with		8842 Willow Wood Way		10f. Zip Code 2 0 7			Og. Citizen of W		States
urs a	by Funeral	11. Marital Status 1 □ Never Married 2 □ Merried 1 □ Never Married 2 □ Merried 1 □ Yes ②□ Wo 1 □ Yes, Give Yeer or Detes:	if '	as Decedent of Yes, specify Cul	Hispanic Origin? (Sp ben, Mexican, Puarto Specify:	pecify Yes or No- p Rican, etc.)	Btec	- Americ k, White, Wh	
72 h	Completed	15. Decedent's Education (Specify only highast grade completed)	16a. Decede	ent's Usual Occu	ipation during most of worled)	16b. Kind of Bus		ustness/Industry	
within ene.	du	College (1-4or 5+)					0.2710	TT come	
a filed v other th	S	1.2 17. Fathar's Name (First, Middla, Last)	Hou	sewife		- 45-14-14-14	Own		e
ntal hod of or	Be	Charles Eckert			18. Mother's Nem	Unkoow		3)	
d 2 should be filed the and Mental Hyg 7 is marked other treumstic event.	2		10h Mailing	Addrage /Ctmc	et end Number or Ru			Chair 74	Codel
d2 s th an treu treu	1	Phyllis Smith / Daughter			Ave. A				
ges 1 and of Heal	1	20a. Method of Disposition 20b. Pled	ce of Disposit	tion (Neme of			20c. Location -		
8 6 # >		4 Donetion 5 Other (Specify)		ark Ce	emetery				re, Md.
permit. F Departm Importan any Injur		21. Signature of Funerat Sovice Licensa		Mbrose	,	L Home,	Inc.	Arb	utus and 21227
100		23a. Part1. Enter the disease, or complications that caused the death.	Do not anter	the mode of dy	ing, such es cardiac	or respiratory em	est,	ry1	Approximate
Physician		shock, or heart failura. List only ona ceuse on eech line.					,	i	Intervat Between Onsat end Deeth
/Medical		Immediata Ceuse (Final diseesa or condition MYOCATA	2011	94	INFAR	20770	N	1	I HR.
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0 0 0	Physician/	Pert il. Other significant conditions contributing to death but not rasulting	ng in the und	lerlying cause g	iven in Pert I.	23b. Did to	bacco use con	tribute to	the causa of death?
that the detay	F	DEMERTIA				1 □ Y	2 2 No	3 Prot	bably 4 Unknown
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v requir been s should	ete					24e. Wes a perform	ned?	eve	eileble prior to mplation of causa
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dcian: certific rector,	Be	25. Was case rafarred to medical axaminer.		0	26. Placa of Deal				
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Ather true	Certification:	1 Natural 5 Panding (Month, Dey Year)	Bb. Time of Injury	28c. Inju Wo	ork?]Yes 2□No	28d. Describe ho	w injury occurre	М	
Attend or death ector: / by the f	Cal	2 Accident investigation 3 Suicide 6 Could not be	. ()			28f. Location (St	and and Alimbar	D	I Doube Atrocker
or A atter Direction of		datarmined 4 ☐ Homicide datarmined 28a. Pleca of Injury - At home building, etc. (Specify)	a, rarm, stree	at, ractory, offica	,	City or Town	, State)	r or Hure	House Numbar,
polital bours filled	2	29a. Certifier 1 Cartifying Physician: To the best of my knowle							
To the Hospital or Attend within 24 hours after death To the Funeral Directors completely filled in by the	edical	29a. Certifier (Check only one) 1 Cartifying Physician: To tha best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	and/or inve	stigetion, in my	ime, date end pieca, opinion, deeth occur	end due to the ca red at the time, da	ausa(s) and mai ate end place, a	nd due to	teted. the cause(s)
diffice of the state of the sta		29b. Signature end titla of critifier		29c, Licen	se number	2	9d. Dete signed	(Month)	Dev. Year)
F S F O		Attiles mo					3/10	19	9
1	-				00/7		110	//	/
0		30. Name and eddress of person who completed cause of death (Itam 2)	3e) (Type, Pr	rint)	8344 d. 212	111	,		
		31. Dete filed (Month, Dey, Year) 32. Registrar's Signetur	allo	7-14	u. 0210	17			
State Registra	-	No.	2	1					
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 Country) **Funeral** 1**2**(M 2□ F Months Deys 258016880 Yrs. April 20 1917 LOUISIANA Director Usuel Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. inside City Limits "natural", or items 23a or 28a-f ahow MARYLAND BALTIMORE ESSEX 1 Yes 2 No Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 822 BRUNSWICK KOAD APT. IA UNITED STATES OF AMERICA 21221 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status pemit. Peges 1 end 2 should be filed within 72 hours after d. Department of Health end Mental Hygiene. Illimportant: if Itam 27 is marked other than "natural", or item any injury or other traumatic avent, in Medical Exercises once. Black, White, etc. 1 Syes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 257 Married Specify: WHITE 1 Yes 2 No Specify: g 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NASHOMOWITZ COMPANY Elementery/Secondary (0-12) College (1-4or 5+) 10TH GRADE ELECTRICIAN 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) POTTS ANNA WATERS WILLIAM 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 822 BRUNSWICK ROAD APT. 1A ESSEX, MD. 21221 MYRTIS OTTS 20b. Place of Disposition (Name of cametery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 M Burial 2 ☐ Cremetion 3 ☐ Removel from State ULANEY VALLEY MEMORIAL MARIGHA COCKEYSVILLE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signature of Funerel Service Licensee 6009 HARFORD ROAD ALTENBURG FUNERAL HOME BALTIMORE, MD. 21214 Watson, M. Moo612 Donald R. 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) PNEUMONIA February 4 1999 Examiner Due to (or es e consequenca of) Examiner attending physician end for use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as e consequenca of): Physician/Medicai Due to (or es e consequence of) signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease 1 Yes 2 No λq 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy Completed Coronary Artery Digease certificate has b lirector, pege 2 s Viabetes Mellitus 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28d Describe how injury occurred 27 Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 1 ENaturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No Director: A 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direc completely filled in by 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. 29e. Certifie edical (Check only one) 2 Medical Examinar: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. License number

State

Registrar

31. Date filed (Month, Dey, Year) MAR 1 7 1999

etach

Natasha Stinson,

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

M. D., 10 10 North Greene Street, Baltimore, MD

P103

1999

March

DHMH 16 Rev 6/95

The law requires that the death certificete be executed

or Attending Physician:

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After t

death.

Division of Vital Records, P.O. Box 68760,

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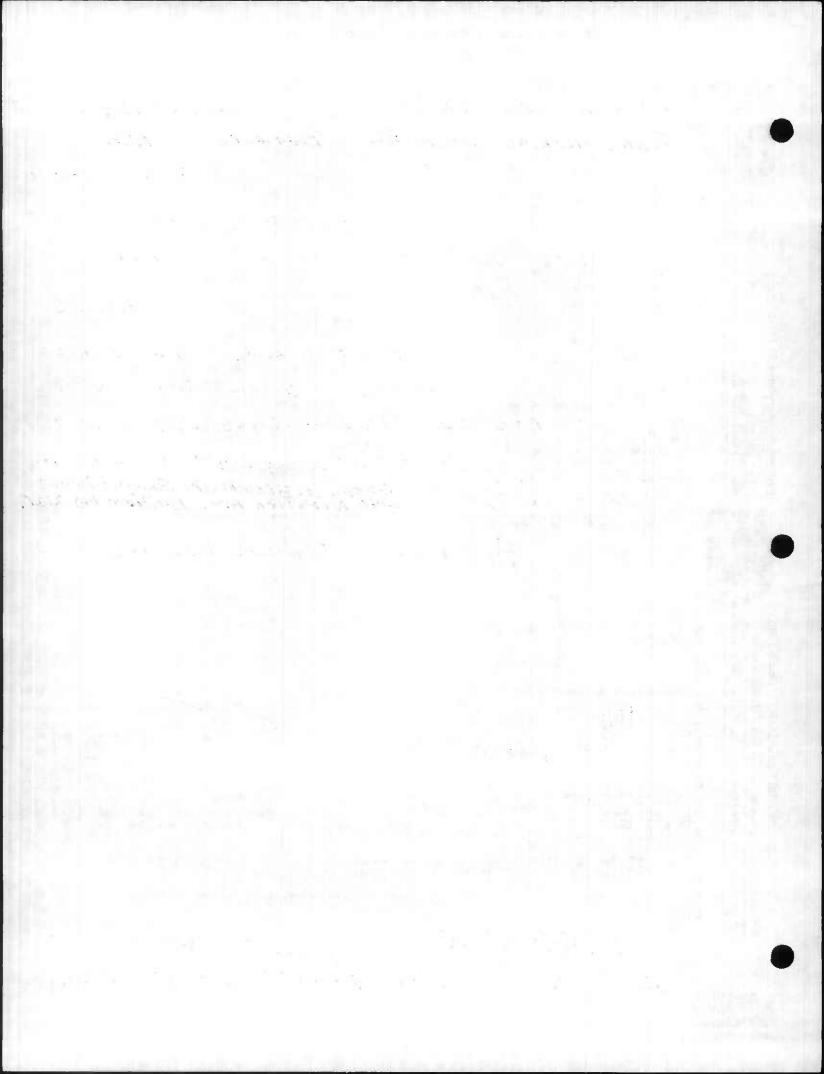
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** 4:34AM BERTHA 1999 MARCH 03 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL HOPKINS BALTIMORE HNS 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 9. Birthplace (Stata or Foraign **Funeral** 2 Yrs. 213-26-299 1 M 20 F Months Days Hours Min **Director** Usual Rasidance of Decedant the Maryland r 28a-f show a notified at 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits Yas 2 No Director MARYLAND 10e. Street and Number 10g. Cilizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or a part ingress of other traumatic event, the Medical Examiner must be an once. STREE 14. Rece - Amarican Indian, UASHINGTON Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) OWN MAKER UNKNOWN 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fether's Nama (First, Middla, Last) Be (MN-UNKNOWN SULTON GESSIE 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) BALTIHORE, MD. 21213 20c. Location - City or Town, Stata EOLA PARKS (DAUGHTER) 1417 N. WASHINGTONST., 20a. Mathod of Disposition 20b. Placa of Disposition (Nema of camatary, cramatory or other placa) Data Burial 2 Cramation 3 Ramoval from Stata CEDAR HILL CEMETERY 83-08-99 GLENBURNIE, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvica Licanses 22. Nama and Address of Facility Funeral Home 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feliura. List only one ceuse on each line. BAltimore MD 21217 Approximata Intarval Between Onset and Deeth Physician lerone CARDIOVASCULAR disease /Medical Immediete Ceuse (Finel disaasa or condition rasulting in deeth) Examiner Examiner physician and s the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): as 980 signed by the a d be detached f 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 100 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 s 1 Yas 2 NO 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Was casa rafarrad to medical axaminar? Be 26. Place of Death (Chack only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To After this 28c. Injury at Work? 27. Menny of Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 1 D Natural 5 Panding 1 ☐ Yas 2 ☐ No 24 hours after death.

Funerel Director: Af investigation 2 Accidant 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide filled in Hospital 1 Certifying Physician: To tha best of my knowledga, daath occurred et tha time, dete end plece, end dua to tha causa(s) and mannar as steted. 29a. Certifier Medical completely 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only one) To the I 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifia

(Itam 23a) (Type, Print)

State Registrar 30. Name and addrass of person

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Physician /Medical Examiner physicien and the bunal-transit certificata be executed Division of Vital Records, P.O. Box 68760,

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Peges 1 and 2 should be filed within 72 hours after death with 1 and of Health and Mental Hydiene.
Int: if flam 27 is marked other than "natural", or items 23e or 3 ary or other traumatic event, the Medical Fauriner must be not

Baltimore, Maryland 21215-0020

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Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest

25. Wes case referred to medical exeminer? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No

Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 D Homicide

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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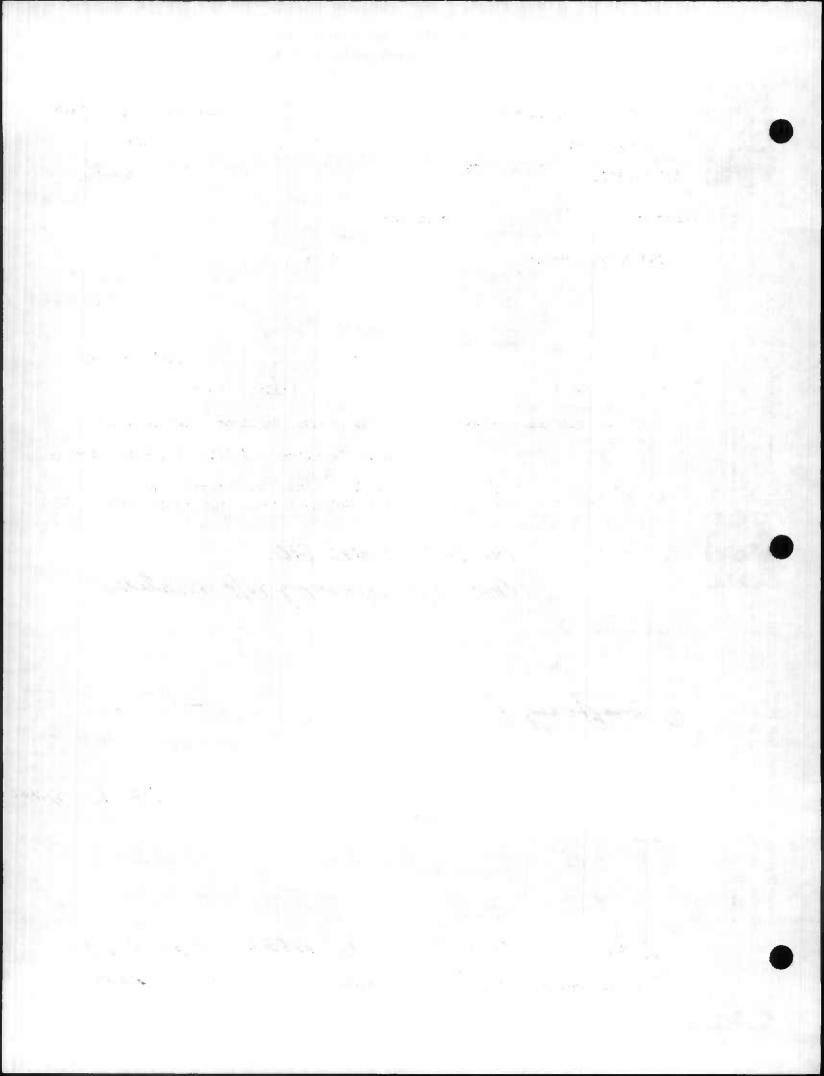
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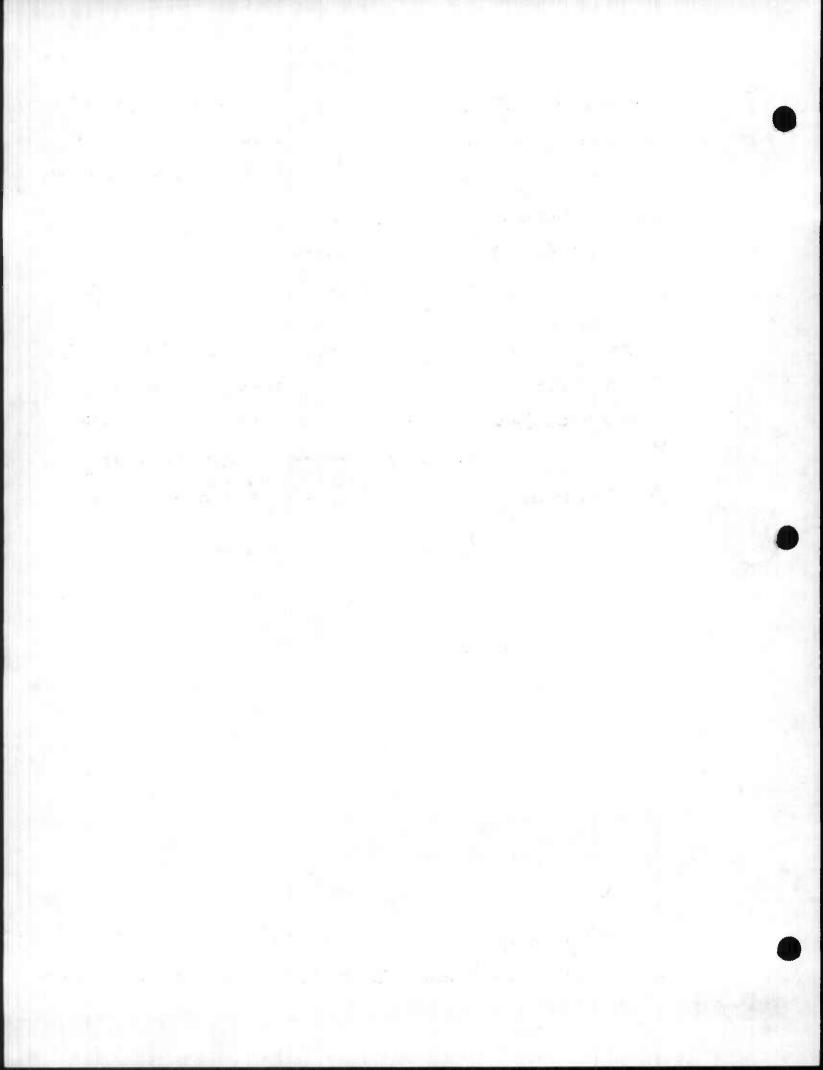
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32. Registrer's Signeture



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	und 2 sho alth end A 27 is ma ir trauma		19a, Informant's Nama/Ralationship			19b. Mailin			and Number or R	urel Routa Numb	ar, City or Town		- 1	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to		20a. Mathod of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Speci		C	Place of Dispose camatary, crem	ition (Nar alory or o	na of othar pla	ca)	Data	20c. Location			
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ox 68760,	E 00 66	Medical	Ceusa. Critar or injury that initiated avants resulting in death) Last	d	Due to (o	r as e consequ	ence of):							
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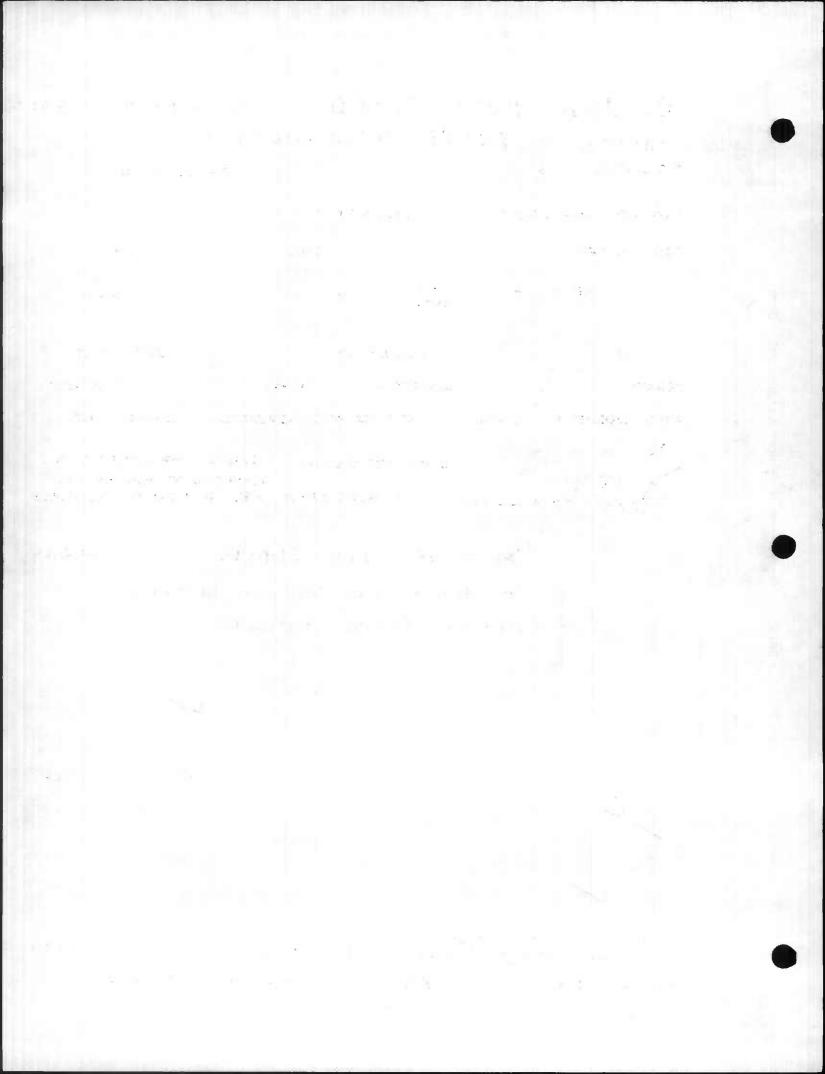
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Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once.	20e. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Nama of camatary, cramatory or other place) CREST LAWN CEMETERY 21. Speciment of Fundam Service Licenses 22. Nama and Address of Facility 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 2										
Box 68760, seth certificate be executed attending physician and for use as the burial-transit claryMedical Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only on the shock, or heart failure. List only on the shock, or heart failure. List only on the shock of	PNEUMON Dua to (o SQUAMO Dua to (o	r as a conseque	JITH ence of): ELL Conce of): NAL	SEps	IA OF		Interve Onsat	ximata al Between and Daath DAYS		
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To the within to the compile	29b. Signature and titla of certifier 29b. Signature and titla of certifier 30. Nema and addrass of person who co	Molested cause of death /fram	1D	29c. Licans	2792		9d. Data signed	(Month, Day, Y	999		
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DHMH 16 Rev 6/95

Registrar

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Physician /Medical **Examiner**

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To the Hospital or Atterwithin 24 hours efter der To the Funeral Director completely filled in by th

the death certificete be execu

Records, P.O. Box 68760

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Baltimore, Maryland 21215-0020

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26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was cese referred to medical axaminar? 1 Yes 2 No 27. Menner of Deeth 1 Naturel
2 Accident

3 Suicide

29a. Certifier

5 Pending investigation

Hospitai:

2 ER/Outpetient 3 DOA 28b. Time of

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

1 Yes 2 No

28d. Describe how Injury occurred

6 Could not be detarmined 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

finer: On the basis of examinetion end/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of dertifler

29c. License number

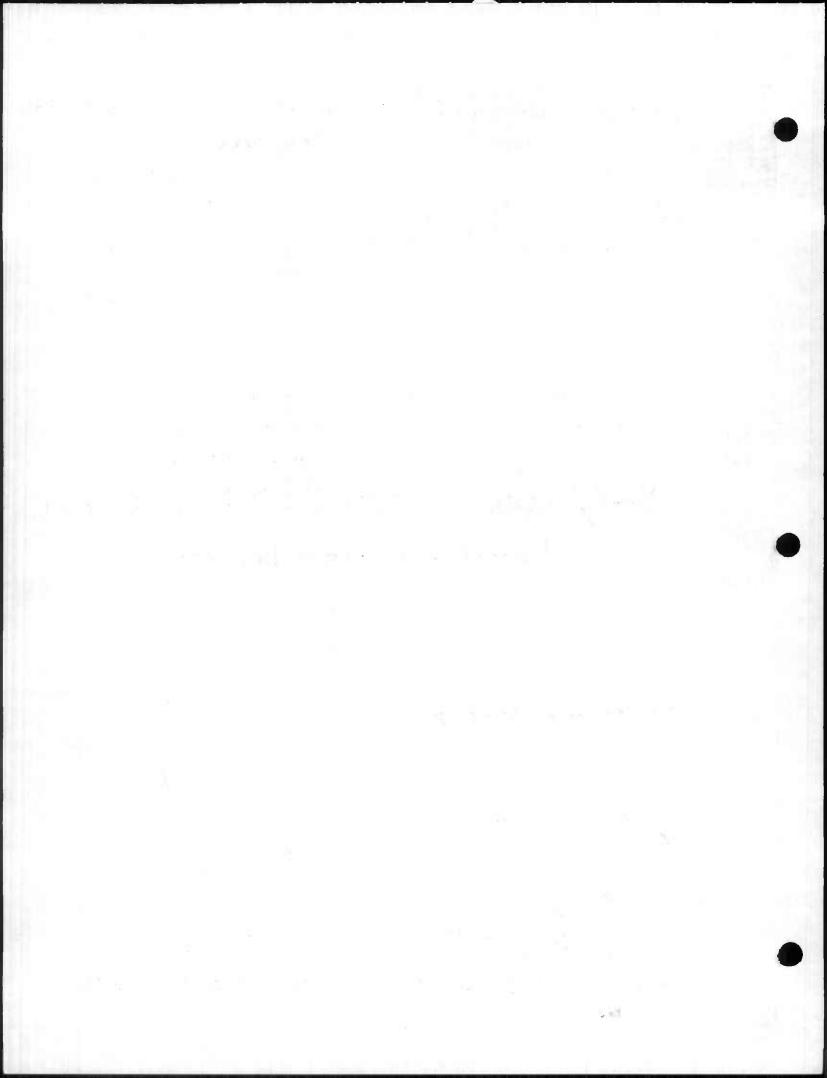
29d. Date signed (Month, Dey, Yeer)

Address of person who completed ceuse of deeth (Item 23e) (Type, Print)

2401 W. BELVEDERE AVE BALTO MD 21215 GINTER MD 32. Registrar's Signature

State Registrar

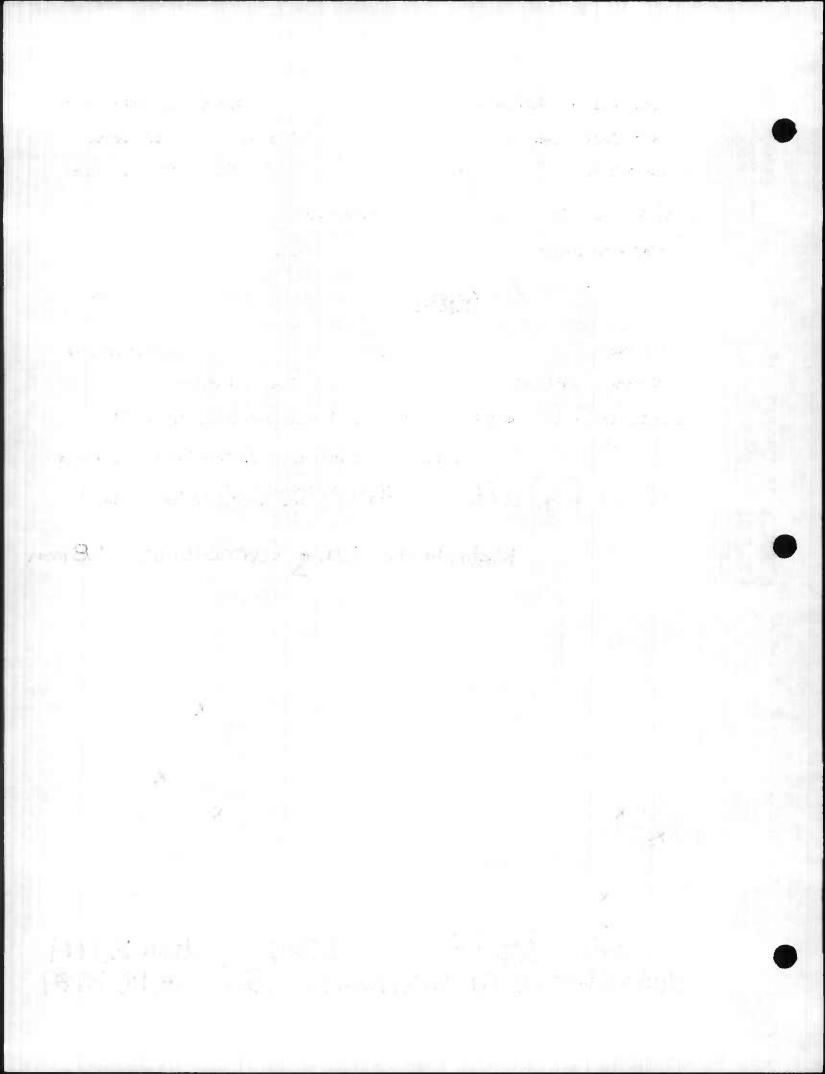
1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Deeth 13, **Physician** March Rutkowski Lawrence J. 2:25 PM /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 4207 Soth Avenue Baltimore. Baltimore 9. Birthplece (State or Foreign Country) Maryland if Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sax 1 M 2 □ F 7. Age (In yrs. lest birthdey) **Funeral** Deys Hours Yrs 216-28-2097 72 Feb. 1, 1927 Director Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Baltimore Baltimore 1 Tyes 2 No Maryland Directo 10g. Citizen of Whet Country? 10e Street and Number 10f Zip Code with 4207 Soth Avenue 21236 U.S.A. Funeral deeth 12. Wes Decedent Ever in U,S.
Armed Forces?
1 X Yas 2 No
If Yes, Give Korean
Year or Detest On Juct 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or its 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: White Specify A 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4or 5+) Welder Tractor Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surname) Be marked William Rutkowski Anna Kowalee 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Rutkowski (wife) 4207 Soth Avenue, Baltimore, MD 21236 other 1 20b. Pleca of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ Removel from State any injury or Green Mount Crematory 3/17/99 Baltimore. Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licansee 22. Name end Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23a. Pert1. Enter the disees shock, or heert failure. selvor complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory errest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Carcinoma /Medical Immediate Ceuse (Final disease or condition resulting in deeth) **Examiner** Due to (or es e consequenca of) Examiner physician end the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events rasulting in daath) Last Due to (or as a consequance of) Box 68760. that the death certificete be Physician/Medical Due to (or as a consequence of) use as 6 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings avellable prior to completion of cause of death? 24a. Wes en eutopsy Completed peen page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Hospital or Attending Physician: director 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpelient 3 DOA this funeral 27. Menner of Deeth Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Dascribe how Injury occurred 28b. Time of Certification: After 1 Naturel 2 Accident 5 Pending Investigation 1 Yes 2 No 24 hours after death. 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, lactory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

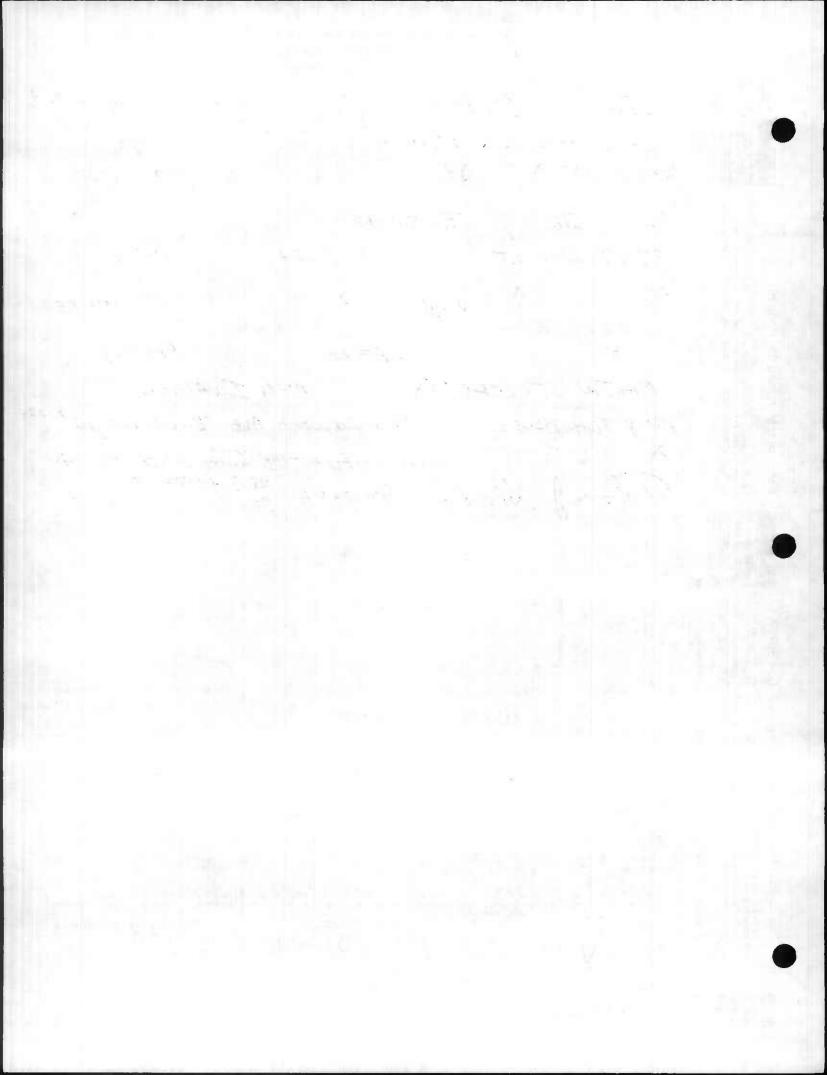
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and dua to the cause(s) 29a. Certifier Medical (Check only one) end manner steted. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifian 29c. Licensa number (Item 23e) (Type Print) Baltimore, M 32. Registrer's Signeture State MAR 17 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg.	. No.	38359			
Physician /Medical	1. Decedent's Nama (First, Middla, Las	STRZEL	CZVK	2. Date of Death Month MARCH	Day /999	3. Time of Death			
/Medical Examiner	4a Facility Nema (If not institution, give	street end number)	4b. City, Town, o	or Location of Death	4c. County of Deat	h			
	CATON HAR	-BOR NURSIA		MOVE	NA				
Funeral Director	5. Social Security Number 6. Security Number 6. Security Number 19 Sec	7. Age (In yrs. lest to	oirthday) If Under 1 Yaar If Undar 24 H Yrs. Months Days Hours Mi		9. Bin 19/0	hplace (State or Foreign puntry)			
pu a m	10a. State 10b. County	10c. City, To	wn or Location			10d. toside City Limits			
the Meryler 28a-1 ahow northed at	MD. N/A	BHI	TIMORE			1XYes 2□No			
or 28,	10e. Street and Number	70	10f. Zip Code	10g.	. Citizan of What Co	ountry?			
23a 23a Za	2731 Di LL-ON	5T.	21224		0.5.A				
ifter death with the Mei river man 2s or 28s-far free man to norilled Funeral Director	11. Marital Status	 Was Decedent Ever in U,S. Armed Forces? 	13. Was Dacadent of Hispanic Origin? If Yes, spacify Cuban, Mexican, Put	(Specify Yas or No- arto Rican, atc.)	14. Race - Ame Black, White				
by	3 ☐ Widowed 4 ☐ Divorcad	1 Yes 2 No fi Yes, Giva Yaar or Datas: WWTL	1 ☐ Yes 2 No Specify:		Specify: W	HITE			
be filed within 72 hours lal Hygiene. d other than "natural", event, the Medical Ex-	15. Decedent's Ed (Specify only highest grad	ucation 16 de completed)	(Give kind of work done during most of w		b. Kind of Business/	Industry			
within has.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		FACTOR	V			
Hygiene ther than	17. Father's Name (First, Middle, Lest)		ABOLEL 18. Mother's N	lema (First, Middle, Mai	iden Sumeme)				
Mental Mental arked or artic eve	MADTA) 5	TRZELCZYK	MAY	Y TWAN					
d 2 should be filed within the and Mental Hygiene. 7 is marked other than traumatic event, the M	19a. Informant's Name/Relationship (7		9b. Malling Address (Street end Number or			Zip Code)			
nd 2 with a	MARY JEAN B	QUEE !	138 S. ELLWOOD	AVE. BA	IT MORE	Zip Code) 2VZZY			
es 1 en of Heeli I Item 2	20a. Method of Disposition	20b. Place	of Disposition (Neme of tery, cremetory or other plece)	Data 20	c. Location - City or				
00	Burial 2 Cremation 3 Donatlon 5 Other (Specify		HLLISON FOREST OFF	11,1999 B	3440 · C	O. MD.			
permit. Page Department of Important: If any Injury or page.	21. Signature of Properal Service Lines	Skale .	22. Nama and Address of Facility SHADA F-H-	1879 HUDS	ON ST.	224			
CHARGE !	23a. Part1. Enter the disease, of comp	lications that causad the death. D	o not enter the mode of dying, such as card	iac or respiratory arrest	1, 1012 70	Approximata Interval Between			
Physician /Medical	Immediata Cause (Final disease or condition	Colar	Concer			Onset end Deeth			
Examiner	resulting in deeth)	a. Due to (or as	a consequence of):						
sit sit		b							
ficete be executed ficete be executed physician and is the buriel-trensit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
artificate be exemple; ing physician eas the buriel.		Due to (or as o	a consequence of):	51,6					
attendin for use		U							
es that the death cer igned by the attendir be deteched for use by Physiclan/A	Part It. Other elgnificant conditions of	AL-Literary	g in the underlying cause given in Pert I.		acco usa contribute 2 □ No 3 □ P	to the cause of death?			
To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within Fuhrers after cleach. To the Funeral Director: After this certificate has been signed by the atjending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit Medical Certification: To Be Completed by Physician/Medical Examin				24a. Was an a performa	id?	Were autopsy findings availabla prior to completion of ceuse of death?			
ne lav				1 ☐ Yes	10	1 ☐ Yes 2 ☐ No			
lician: The lav certificate hes rector, page 2	25. Was cese referred to medical		26. Place of D	Death (Chack only one)					
hysicie his cer il direc	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Othor	g Home 5 ☐ Residence	ce 6 □Othar (Spe	ecify)			
To the Hospital or Attending Physician: The law require within 24 hours after deeth. To the Funeral Director: After this certificate hes been significated in by the funeral director, page 2 should Medical Certification: To Be Completed	27. Mannar of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Dey Year)	o. Time of tnjury et Work? M 1 □ Yes 2 □ No	28d. Describe how	Injury occurred				
or Attendant of At	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	ferm, street, factory, office	28f. Location (Stree City or Town,	et and Number or R Stete)	turel Route Number,			
To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	29a. Certifier Certifying Phy	Iner: On the basis of examination	ge, death occurred at the time, date end pla and/or Investigation, in my opinion, death oc						
ithin 2 or the comple	and manner steted. 29b. Signature and title of configer 29d. Date signed (Month, Day, Year)								
F 3 F 8	X		024276		3 999				
1 1	30. Name and address of pirson who d	ompleted cause of death (Item 22)	<u> </u>		, ,				
10.	,	Han Zfel		21224					
State Registrar	31. Date filed (Month, Dey, Year) MAR 1 7 1999	62. Registrar's Signature							
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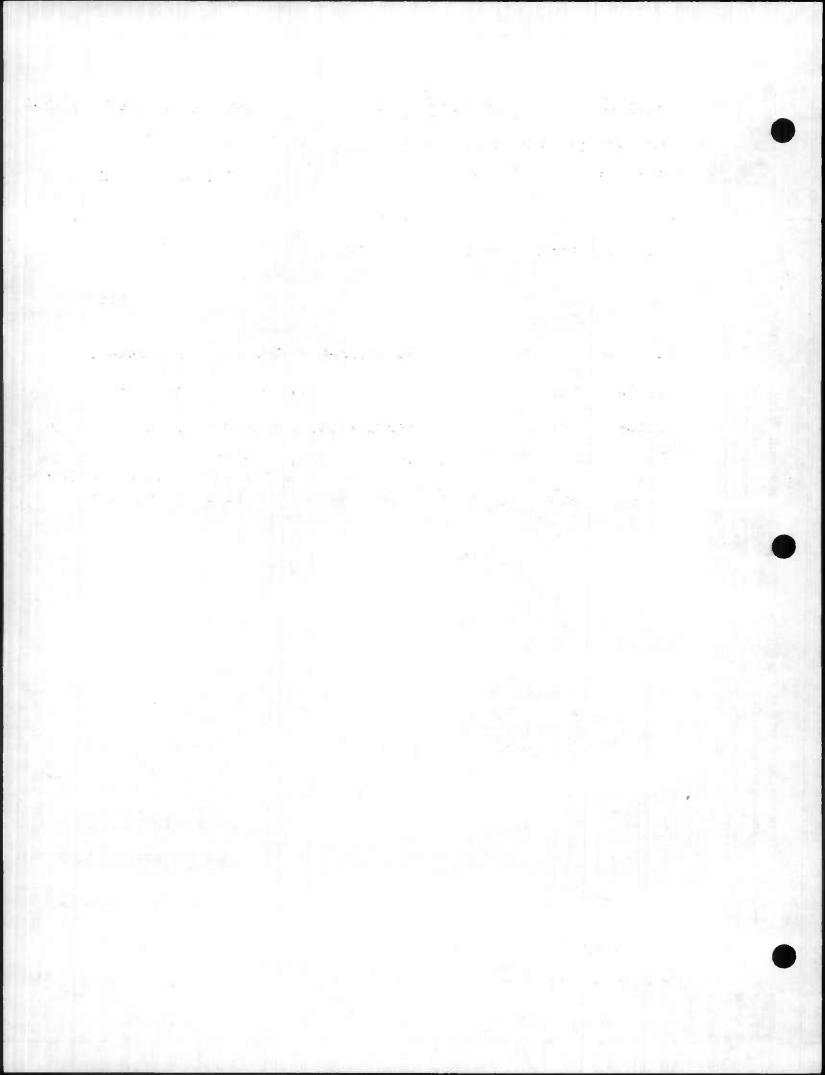


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedant's Nema (First, Middle, Last) **Physician** :15AN March /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Harford Gardens Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Yaar 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M **3**□ F Months Deys 211-16-7325 83 Yrs Director SC 02-14-16 Usual Rasidence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. inslda City Limits 7 is marked other than "natural", or frems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at MD Yes 2 No NA Baltimore Director 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? with 21213 1618 E. Hoffman Street USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No if Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yas 2 No Specify: Specify: Black þ 3 € Widowad 4 □ Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pagas 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: If item 27 is marked other than " Elementery/Secondary (0-12) Collega (1-4or 5+) 6th Grade NA Restaurant worker Restaurant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Sumema) 10 Willie Dewitt Janie Jackson 21239 19b. Mailing Address (Straet end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 1642 Hartsdale Road Baltimore, Maryland Dete 20c Location City or Town, Stete other t Janie Simon altimore. 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20e. Method of Disposition 18 Burial 2 Cremetion 3 Removal from State any injury or Mt. Auburn Cemetery 03-19-99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue missions that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest or one cause on each line. 23a. Pert1. Enter the disease, or com shock, or heart feilure. List only Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel LUNG MASS disaasa or condition resulting in death) Examiner Examiner neumonia ician and burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or as a consequence of) physician nouma 99 Physician/Medicai the Due to (or es e consequence of) 88 esn 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? ed by the a Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed l A 24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 24a. Was an autopsy Completed peen 1 Vac 2 DA 1 □ Yes 2FINO cartificate or Attending Physician: funeral director. 25. Wes case referred to medical Be 26. Pleca of Deeth (Check only one) Other: 4 Horsing Homa 5 Rasidance 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Deta of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending 1 Neturel aftar death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours e Hospital 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end mannar steted. 29d. Dete signed (Month, Dey, Year) 29b. Signetura end title of certifian 29c. License number 31464 MI) 3116 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)
CHA(12 A HASHMI. 821 N. EUTAW St. Fmite 308 MD 31. Dete filed (Month, Day, Yeer)

32. Registrer's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death Month 540 1999 March 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, or Ba timore Medical Mariand N/A Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) Months Deys Hours 15□ M 2□ F 42 215-70-6370 Aug. 28, 1956 Maryland Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits Maryland 10e. Street end N/A 1X Yes 2 No Baltimore 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3625 Keswick Road 21211 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Specify: White 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☑ Divorced Yeer or Detes: Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Painter Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles Albert Stevenson Marie Catherine Debus 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Marie Stevenson (mother) 3645 Keswick Road, Baltimore, Maryland 21211 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stele 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Cemetery 3/19/99 | Baltimore, Md 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility A. Alan Seitz, Jr. Funeral Home 23a. Pert1. Enter the disease, or complications that out and the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate Approximate Approximate Intervel Between Onsel and Deeth tmmediete Ceuse (Final disease or condition resulting in death) Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 3 Probably 4 Unknown t ☐ Yes 2 ☐ No 24b. Were autopsy findings aveileble prior to 24a. Was en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 28. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Examiner

Physician/Medical

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Certification:

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Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at

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permit. Pages 1 end 2 should be in Depertment of Health end Mental important: If item 27 is marked or

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Baltimore, Maryland 21215-0020

pue physicien eu attending 0 the the signed by t peen has page 2

The law requires that the death certificate be executed

or Attending Physician:

Hospital

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within 2 To the

Division of Vital Records, P.O. Box 68760,

certificate director this After this n 24 hours efter death. death.

25. Wes case referred to medicat examiner? 1 Yes 2 No 27. Menger of Deeth 1 Neturel 2 Accident

4 Homicide 29a. Certifier (Check only one)

29b. Signature

3 Suicide

5 Pending

investigation 6 Could not be determined

1 Inpatient 28e. Date of Injury (Month, Dev Year)

28b. Time of 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

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28d. Describe how injury occurred

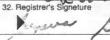
11 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es stated.
2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

who completed cause of deeth (Item 23e) (Type, Print)

Street Baltimore South Greene Wendy

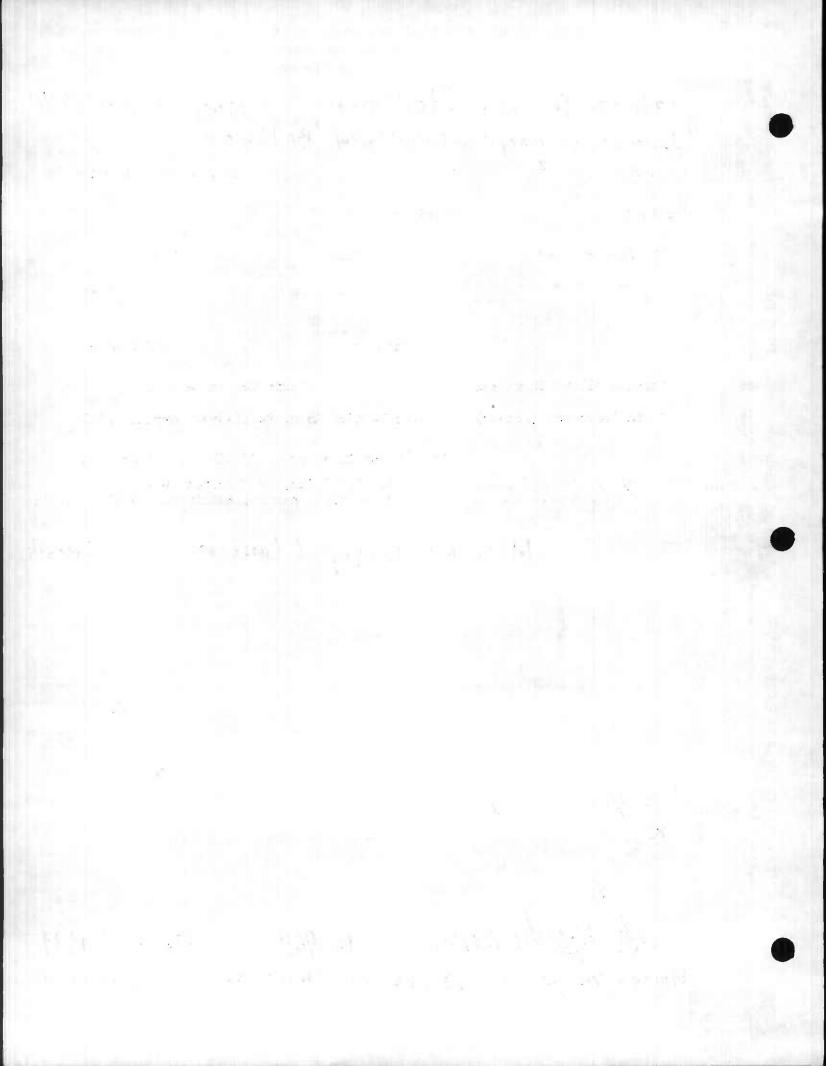
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State Registrar

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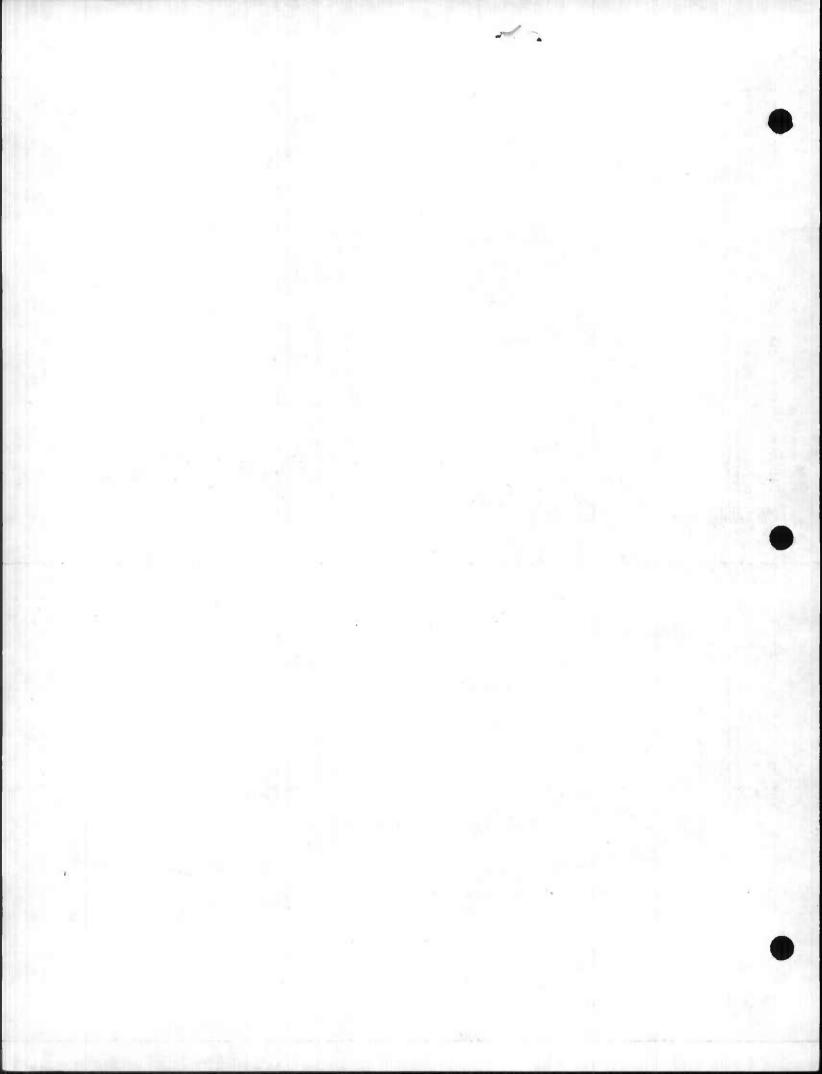


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State of Maryland / Department of Health and Mental Hygiene (

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	Certificate of Death	Reg. No.	00002		
Physician /Medical	1. Decedent's Nama (First, Middle, Last) Rosa Sherman	2. Data of Death Month Day May Mo	Year 1956 \$ (0)		
Examiner			y of Death Limane		
Funeral Director	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 94 Yrs. 6. Sax 1 Months Days Hours Min		9. Birthplace (State or Fore Country)		
anyland show d.at	Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location		10d. Inside City Lim		
with the Mary t or 28s-f st be notified Director	MD BALTIMORE 10e. Street and Number 10f. Zio Code	140 077 /	1 Yas 2		
er death with the Maryla thems 23s or 28s-1 sho ner mast be notified at 'uneral Director	3018 HARFORD RD. 10f. Zip Code 21218	U.S.A.			
Exami		(Specify Yes or No- orto Rican, atc.) 14. Rai Bla Specifi	ce - American Indian, ick, White, atc. ^{5/2} : BLACK		
dical disa	15. Decedant's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	orking 16b. Kind of 8	Businass/Industry		
ed within 72 ho ypene. wer than "naturi ft, the Medical.	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) 12 HOME MAKER	номе			
Mental Hy arked oth affic event		ama <i>(First, Middle, Maiden Sumai</i> ETH: THOMAS	пе)		
M pun	19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or I	Rural Route Number, City or Town	, State, Zip Code)		
27 b	JACQUELINE WINKLER 3018 HARFORD RD. BAL	TIMORE MD. 21218	3		
of He rother	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location	- City or Town, Stata		
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Depart Import any in	21. Signatura of Funeral Sarvice Licensee 22. Nama end Addrass of Facility E 1300 EUTAW PLAC	STEP BROTHERS FUE BALTIMORE MD.			
	23a. Part1. Entar the of sease, or complications that caused the death. Do not entar the mode of dying, such as cardi shock, or heart tailure. List only one cause on each line.	ac or respiratory arrest,	Approximata Interval Between		
hysician /Medical	Immediata Ceuse (Finel disaasa or condition Multiple Bacterial Ass		Onset and Deat		
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g physician and as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events		101		
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	resulting in death) Lest Dua to (or as a consequence of): Severe male mutt it to a		zyr.		
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cate has been signed by the attendir page 2 should be detached for use Completed by Physician/R		24a. Was en eutopsy performed?	24b. Ware autopsy tindir available prior to completion of cause of death?		
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	25. Was cesa rafarrad to medical examinar? 26. Place of D	eath (Check only one)			
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within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (2 Accident 3 Suicida 4 Homicida M 1 Yes 2 No	□ No 28f. Location (Street and Number or Rural Routa Num City or Town, State)			
in 24 hours the Funeral pletely fille edical C	29a. Certifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and plant of the basis of axamination end/or invastigation, in my opinion, deeth occurred and mannar stated.	ce, and due to the cause(s) and m curred at the time, date and place,	annar es stated. end due to tha cause(s)		
To the comple	29b. Signature and titla of certifier 29c. License number	29d. Date signe	ed (Month, Day, Year)		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	746 Imarch	15,1989		
200	Ydo-Ydo Zhu Unión Memorial Hos	pital Balt	imare, M!		
State Registrar	31. Date filed (Month, MARr) 7 1999 32. Registrar's Signature 6. Local	\			



State of Maryland / Department of Health and Mental Hygiene Q QQQQ

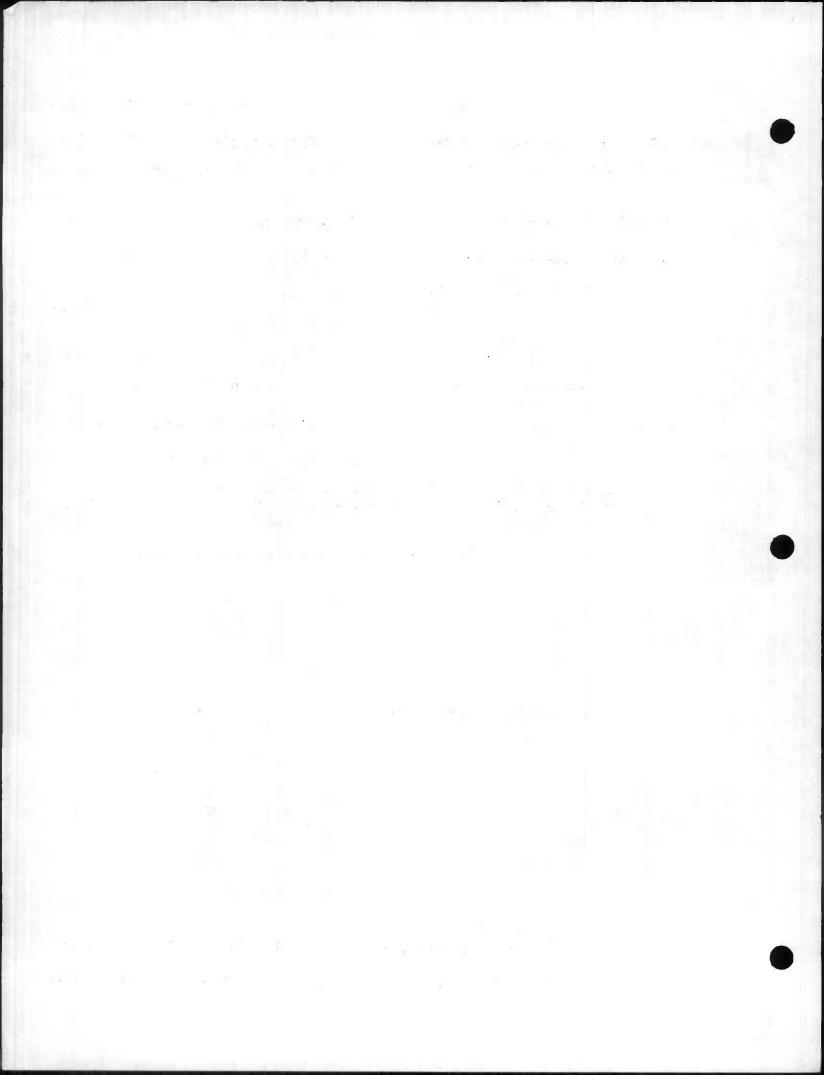
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	or 28s	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	Whet Coun	try?
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee MC	-)mal	A C:	Name and Addr	ess of Fecility n Socie	tv of M	arvlar	nd.	Inc.
	Physician		Dawn F. 23a. Pert1. Enter the diseese, o shock, or heart failure. List	only one cause on ea	ich line.	th. Do not ent	99 Fred er the mode of dy	erick R ing, such es cerdiac	oad Ba or respiratory err	1timo	ce, I	MD 21228 Approximate Intervel Between Onset end Death
	/Medical Examiner	7	Immediate Cause (Finel disaese or condition resulting In deeth)	e. End		C H Ro		STRUCTIVE	PULMO	NARYD	ISENE	nos-year
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Division	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28e. Plece of Injury - At home, farm, street, fectory, office City or Town, State)									il Routa Number,
	Hospi 14 hou Funer taly fill	Medical		ng Phyeiclan: To the l Examiner: On the ba and mann	sls of examine							
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	5		30. Name and address of person	FOZ LOVS (L)		7 A I D	er C	HOICE	CANE	BAR	20,	6,1999 MD 21228

State Registrar

31. Date tiled (Month, Day, Yeer)

MAR 1 7 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death SERVARY ROSE March 54 1999 05:32 Am 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore City Union Memorial Hospital If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar Birthplaca (Stata or Foreign Country) Days 10 M 20 F Months 217-26-5944 95 13, 1904 Baltimore, Md. Usual Rasidence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore City Md. N/A 1 X Yas 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 5613 Plymouth Road United States 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Giva Year or Dates: 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Seamstress Drapes 6 17, Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Charles Belschner Marie Klaproth 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Marie L. Servary (Daughter) 5613 Plymouth Rd. Baltimore, Maryland 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial 3/8/99 Maryland 4 □ Donation 5 🗷 Other (Specify) Entompment Timonium 21. Signature of Funaral Sarvice Licensee Milton, J Knight Jr 22. Nama and Addrass of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, only one cause on each fine. 23a. Part1. Entar tha disaasa di shock, or haart failura. Litt Approximata Interval Batween Onsat and Death tmmediata Causa (Final Torsades horer diseasa or condition rasulting in death) Myecardial Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 20 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 XNO 26. Placa of Death (Check only ona) 1 Inpatient

Physician /Medical Examiner

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Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific

To the Hospital or A within 24 hours ster To the Funeral Direcompletely filled in b.

Division of Vital Records, P.O. Box 68760

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altimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be

Medical Certification: To

25. Was case referred to medical axaminar? 1 ☐ Yas 2 ☐ No 27. Mennar of Death

1 Netural 5 Pending 2 Accident 6 Could not be detarmined 3 Suicide 4 Homicide

invastigation

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28h Time of

28c. Injury at Work? 1 | Yas 2 | No

Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Describe how injury occurred

Bultimore, M.D. 2/2/8

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, end dua to the cause(s) end mannar as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier

29a, Certifier

29c. License number 2438946

29d. Date signed (Month, Day, Year) March 04, 1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

PEZOZNG GAD Union Memorial

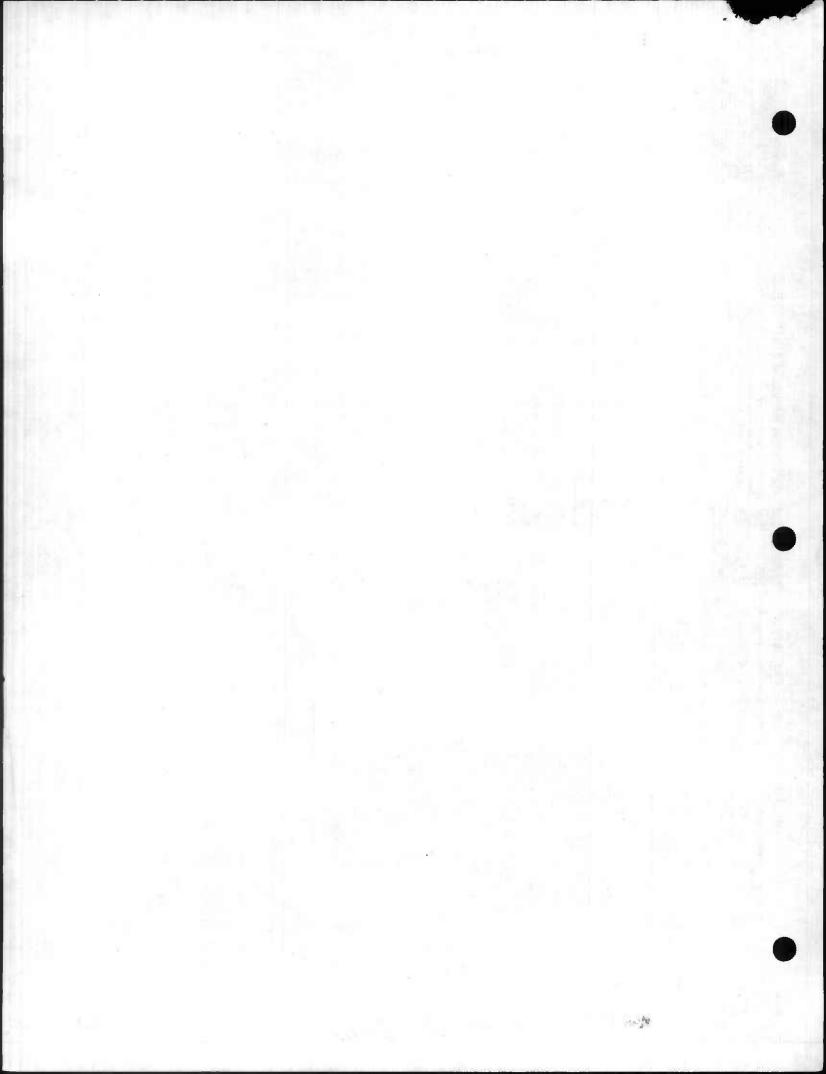
31. Data filed (Month, Day, Year)

32. Registrar's Signature

7 1999

DHMH 16 Rev 6/95

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OHN SerGi B MARCH 9:1010 13, 1999 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death RD. JOPPA BAUTO. Co. E. Nozwol If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1MM 2□ F 88 Months 217-07-9754 MO. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTO. 1 ☐ Yas 2 ☐ No OWSON MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? JOPPA RDs 2-1204 USA 1000 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 20 No Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry FIRE SAFETY Elementary/Secondary (0-12) College (1-4or 5+) FIRE FIGHTER 10 /A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ANTHONY ARY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLENDALE DR. TOWSON 21286 ouls Sen G 20b. Place of Disposition (Name of gemetery, cremetory or other place) 20a. Method of Disposition **Gate** 20c. Location - City or Town, State La Burial 2 ☐ Cremation 3 ☐ Removal from State REDEEMER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility ELLA NOCE + SONS FUNERAL HOME Balto, 21202 322 S. HiGH 57-23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

The lew requires that the death certificate be executed

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within 24 hours To the Funeral I completely filled

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Medical Certification:

Box 68760,

P.O.

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Physician

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10a. State

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Pages 1 and 2 should be filed within 72 hours etter deeth with the Maryler neart of Healib and Mental Hygiene.
Intt. If them 27 is marked other than "natural", or frems 23a or 28a-f show ury or other trearmatts event, its Medical Estimate mast an ordinada.

Inty or other trearmatic event, its Medical Estimate.

21215-0020

Baltimore, Maryland

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical þ Completed

25. Was case referred to medicat examiner?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR-Suite 507, Baltimore, MD 21204

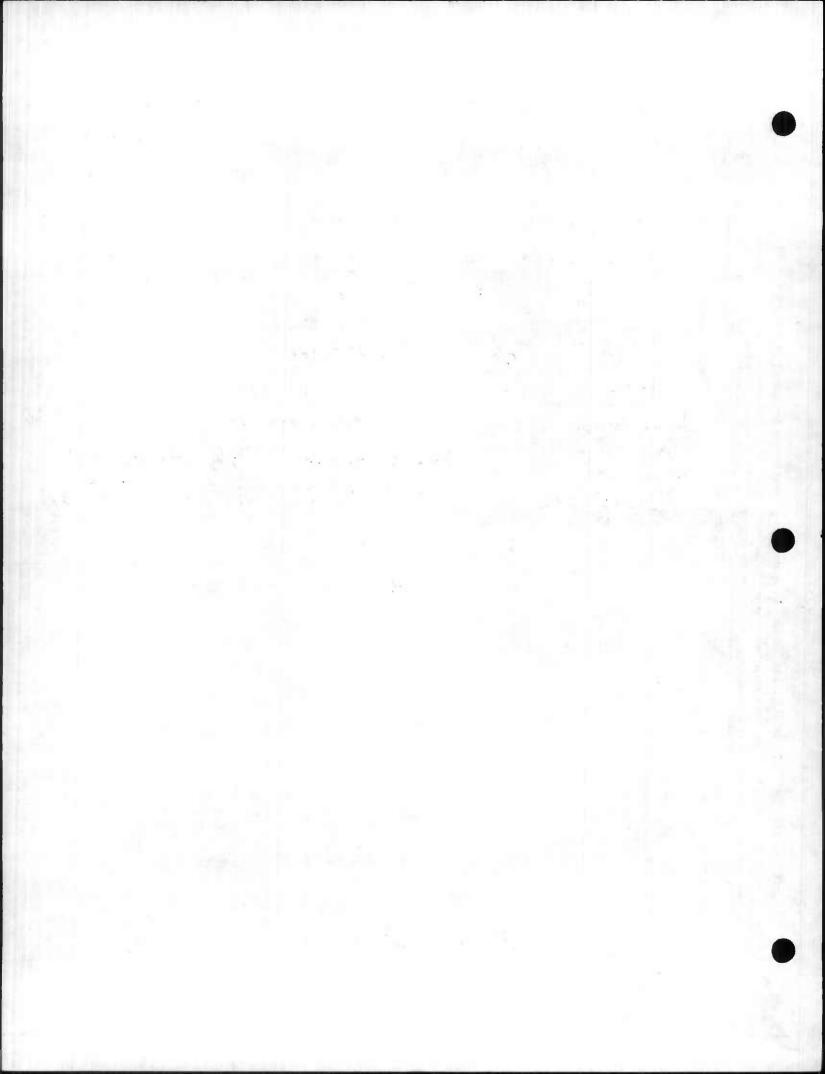
29d. Date signed (Month, Day, Year)

Rerre MO. 120 Sister

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 1999^{Yeer} Dey John Spencer Speer 09. 11:22 PM 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 4 Ballycruy Court Unit 201 Baltimore Co. Timonium 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 07, Year) 1944 9. Birthplece (Stete or Foreign 7. Age (In vrs. lest birthdey) Months Deys Hours 1X M 2□ F 219-42-9798 54 Yrs. Baltimore, Maryland Usual Residence of Decedent 10e State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Timonium 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 4 Ballycruy Court Unit 201 21093-6576 United States of America 12. Wes Decedent Ever In U.S. Armed Forces? 1 ⊠ Yes 2 □ No 3/17/64 If Yes, Give Yeer or Detes: 8/30/65 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Stetus Bieck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementery/Secondary (0-12) Salesman n/a Retail Sales 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) John Somers Speer Rose Eleanor Hasselbach 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Mrs. Sallie J. Noto (Sister) 109 Chargeur Road Reisterstown, Maryland 21136 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from State Hilltop Service Corporation 3/11/99 Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 21. Signature of Funerel Service Licensee an 1050 York Rd. Towson, Md. 21204 d Pent . Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) SYEAVS Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or as e consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 4 Unknown 1 Yes 2 No 3 Probably 24b. Were eutopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel exeminer? 26. Plece of Deeth (Check only one) No No Other: 4 Nursing Home

Physician /Medical Examiner

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Physician

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Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mantel Hygiene.
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Baltimore, Maryland 21215-0020

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1 ☐ Yes

27. Menner of Deeth

Naturel 2 Accident

3 Suicide

4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: this funeral Director: A nin 24 hours oft the Funeral Di npletaly filled in

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the dausets) and includes a date and piece, and due to the causets) and medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as steted. 29d. Date eigned (Month, Day, Year) 29b. Signeture enumber of certifier 29c. License number

3 DOA

28c. Injury et Work?

1 Yes

2 No

5 Residence 6 Other (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

SCAVELLA, MD GIREENE ST BALTIMORE, MD 31. Dete filed (Month, Day, Yeer)

State Registrar

Medical

5 Pending investigation

6 Could not be determined

32 Registrer's Signeture

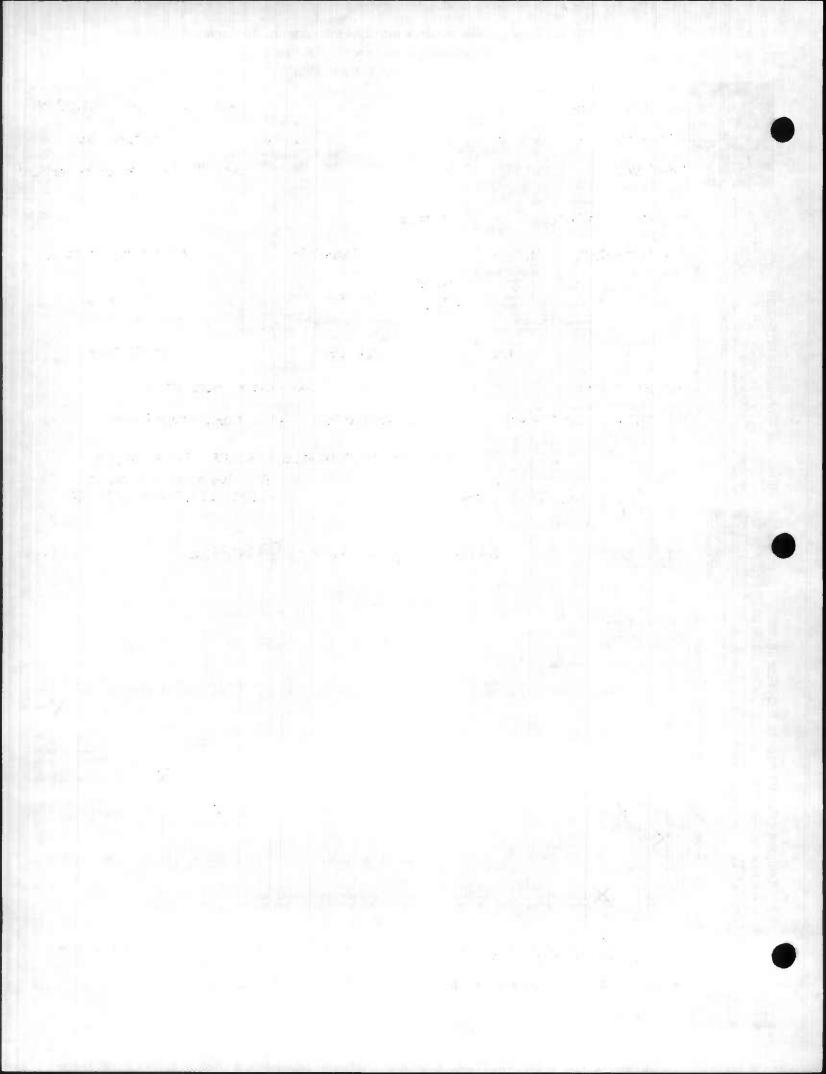
1 ☐ Inpatient 2 ☐ ER/Outpetient

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28e. Dete of Injury (Month, Dey Year)

To the Within 2 To the



Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\text{\text{\$\text{\$}}} \)

							Cer	tificat	e of	Death			Reg.	No.			
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/Medic Examir		4a. Facility Nama (If not institution	, give :	street end nur	nber)					4b. City, To	wn, or L	ocation of Dea	th	4c. County	of Death		
		Stella Maris	Но	spice					1	Timon	ium			Balt	imore		
Funeral		5. Sociel Sacurity Number	6. Sex	(7. Age (In)	yrs. lest bir	thday)	If Under		If Undar		8. Date of B	irth V	· · ·	9. Birthpl	ece (Ste	te or Foreign
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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** March Howard Wesley Seaks 8:00 pm. /Medicai 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1939 Hamover Pike Hampstead Carroll If Under 24 Hrs. 8. Date of Birth Month, Day Y June 14 6. Sex. 1 ■ M 2 □ F 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funerai** Deys Months 217-22-7776 89 Maryland Yes Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Maryland Carroll Hampstead 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? b must be 1939 Hanover Pike 21074 natural, or Items 23a U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 26 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bieck, White, etc. the Medical Examiner. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "nu Elementary/Secondery (0-12) College (1-4or 5+) Owner & Operator Dept. Store 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 20 William H. Seaks Virginia Belle Inghan 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health as Important: if them 27 is any injury or other trau Helen N. Seaks - wife 1939 Hanover Pike, Hampstead, Md. 21074 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removal from State Greenmount Church Cem. March 18.1999 Hampstead. Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final diseese or condition 43 **Examiner** Physician/Medical Examiner The law requires that the death certificete be executed physician end s the burief-trens Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of) for use es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco usa contributa to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown signed be del Records, by 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? peeu pege 2 s 1 Yes 21 No 1 ☐ Yes 2 ☐ NO certificete Division of Vital al or Attending Physician: T setter death.

In Director: After this certificet ed in by the funeral director, pu 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Neture 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 4 Homicide To the Hospital or A within 24 hours efter To the Funeral Direcompletely filled in b edical 29a. Certifier t🗄 Certifying Phyelclan: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signeture end title o 29c. License number 29d. Date signed (Month, Dey, Year) 33165 3116/69 30. Name end eddress of on who campleted cause of deeth (Item \$3e) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrer's Signetu State MAR 17 Registrar

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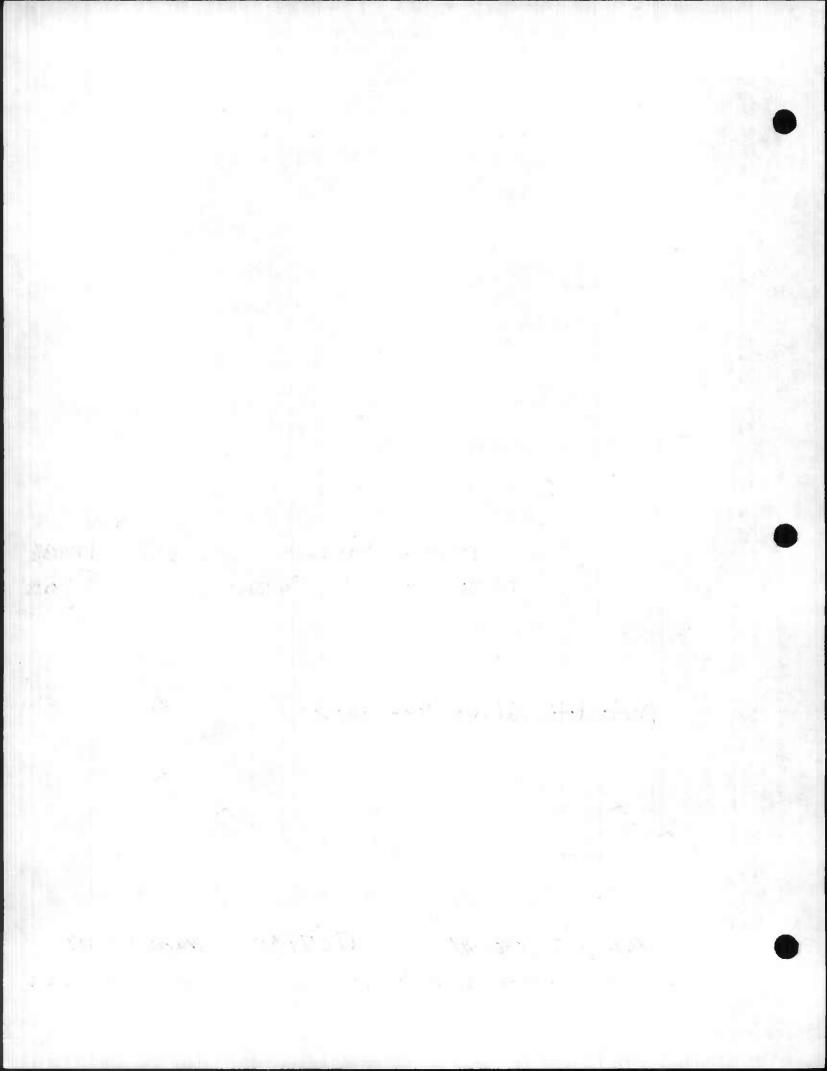
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Funeral Director	7407 Chesapea	ike Ave.		10f. Zip Code	21219		10g. Citizen of V	What Country?	
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ŀ	Part II. Other eignificant conditions	contributing to death but	not resulting in the	underlying cause gi	iven in Part I.	23b. Did	tobacco use co	ntributs to the	e cause of death?
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		V				24a. Was	an sutopsy omed?	availal	eutopsy findings bla prior to etion of cause
							,	of dea	
						10	Yas 2 Digo	1□ Y	as 2 No
	25. Was case refarred to medical axaminer?					ath (Check only	ona)		
-	1 Yas 2 Tho	Hospital: 1 Inpatier	t 2 ER/Outpatio	ent 3 DOA	ther: 4 Nursing h	lome 5 Rasi	denca 6 □Ott	nar (Specify)	
	27. Mannar of Death 1 Naturel 5 Pending 2 Accident invastigat	28a. Data of Injury (Month, Day	Year) 28b. Tima Injury	Wo	ury et ork?] Yes 2 No	28d. Dascribe	how injury occur	red	
	3 Suicide 6 Could not detarmine	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)							
	29a. Cartifier Check only one) Certifying I Check only 2 Medical Exc	Thysician: To the best of aminer: On the besis of and manner state	axamination and/or i	th occurred at tha t nvestigation, in my	ima, data and place opinion, death occu	i, and dua to tha urred at tha tima,	cause(s) end m data and placa,	anner as state and dua to the	d. a cause(s)
Σ	29b. Signatura and titla of certified	100		29c. Licen	se number		29d. Date signe	d (Month, Day	v, Year)
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е	31. Deta filed (Month, Day, Year)	32. Registre	9 DIVIBITIES C						

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3 Time of Deeth 1. Decedent's Nama (First, Middla, Last) 2 Date of Death **Physician** MARCH 11,1999 Stem 18:30 pm Sylvester Wilbur /Medical BALTIMORE |

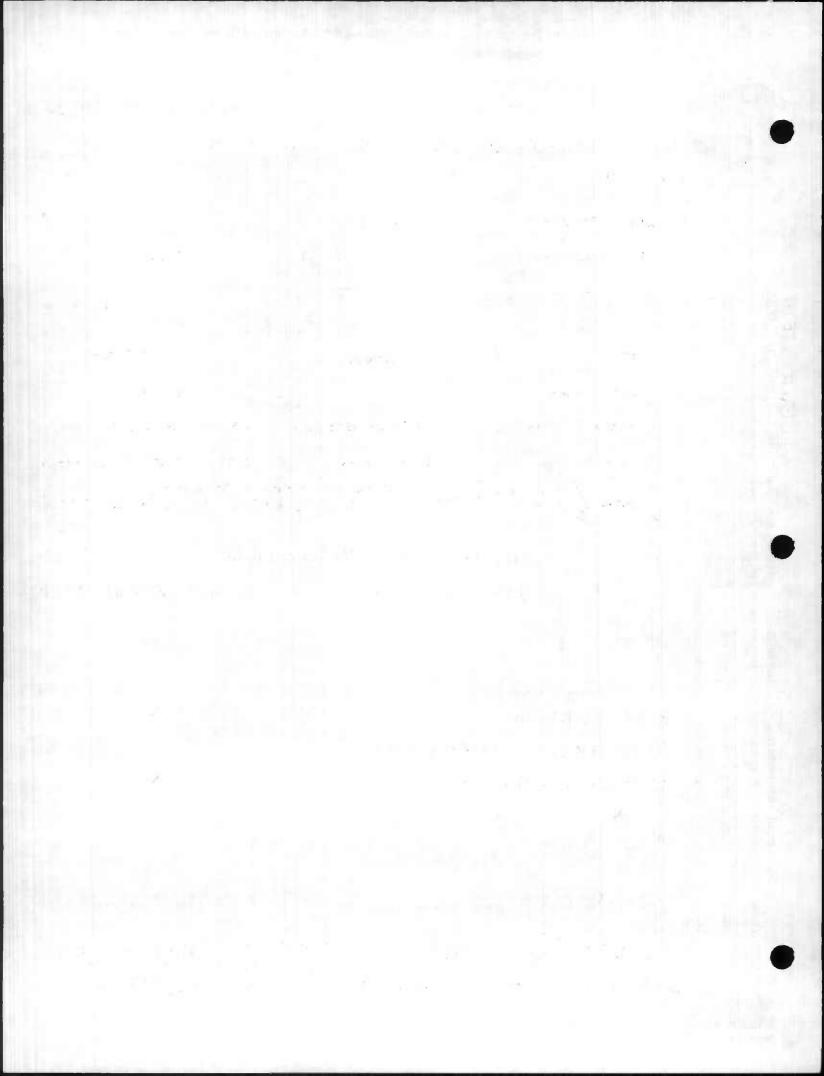
last birthday) | H Under 1 Year

Months | Deys 4h City Town or Location of Death 4e Fecility Neme (If not Institution, giva street and number) Examiner BALTIMORE
If Under 24 Hrs. 8. Dete of Bi SINAI HOSPITAL OF 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□ F Director 218-10-9847 80 Maryland Usual Residence of Decedent with the Meryland 10e Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Directo Woodstock 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? 3102 Granite Road 21163 U.S.A. death v Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritai Status filed within 72 hours after 1 ☐ Yes 212 No If Yes, Give Year or Datas: 1 ☐ Never Merried 2 ☑ Merried Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cottege (1-4or 5+) 10 n/a Steel Company Foreman 17. Fethar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Peges 1 and 2 should be nent of Heelth and Mental Jessie Stem Mary Orendorff 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e, Informent's Neme/Rejetionship (Type, Print) Item 27 I Mrs. Bertha L. Stem 3102 Granite Road Woodstock MD 21163 timore, Important: if item. 20b. Ptece of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 DBurial 2 ☐ Cremetion 3 ☐ Remove from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery Woodlawn, Maryland 22. Name and Addrass of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiretory errest, or hear feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical . ASPIRATION PNEUMONIA 2SDAYS **Examiner** Physician/Medical Examiner 40 DAYS OCCIPITO PARIETAL INFARCTION ettending physician and for use as the buriel-transit the deeth certificate be executed Sequentially list conditions, if eny, teeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest P.O. Box 68760. Dua to (or es e consequenca of): esn Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yee 2 No 3 Probably 4 Unknown HYPERTENSION Division of Vital Records. by 24b. Were eutopsy findings aveilable prior fo completion of cause of death? been signature 24a. Wes en eutopsy performed? Completed MYOCARDIAL INFARCTION hes he 2 certificate he irector, pege CANCER 1 Yes 2 1 No 1 ☐ Yas 2 ☐ No BLADDER 25. Was cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitai: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this Certification: 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred or Attending 1 Neturet 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 Could not be determined 28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide • Funeral Dire after Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end manner steted. 29a. Certifier Medical (Check only one) To the I within 2 To the I complet 29b. Signature and title of contilion 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) SIWAI HOSPITAL OF BALTIMORE

JOSEPHIWE OILIUSU - SAKYLOUAL LAISET OF COMPANY OF BALTIMORE P11333 JOSEPHINE ONUSU-SAKYI, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21044 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State MAR 1 7 1999 Registrar

DHMH 16 Rev 6/95



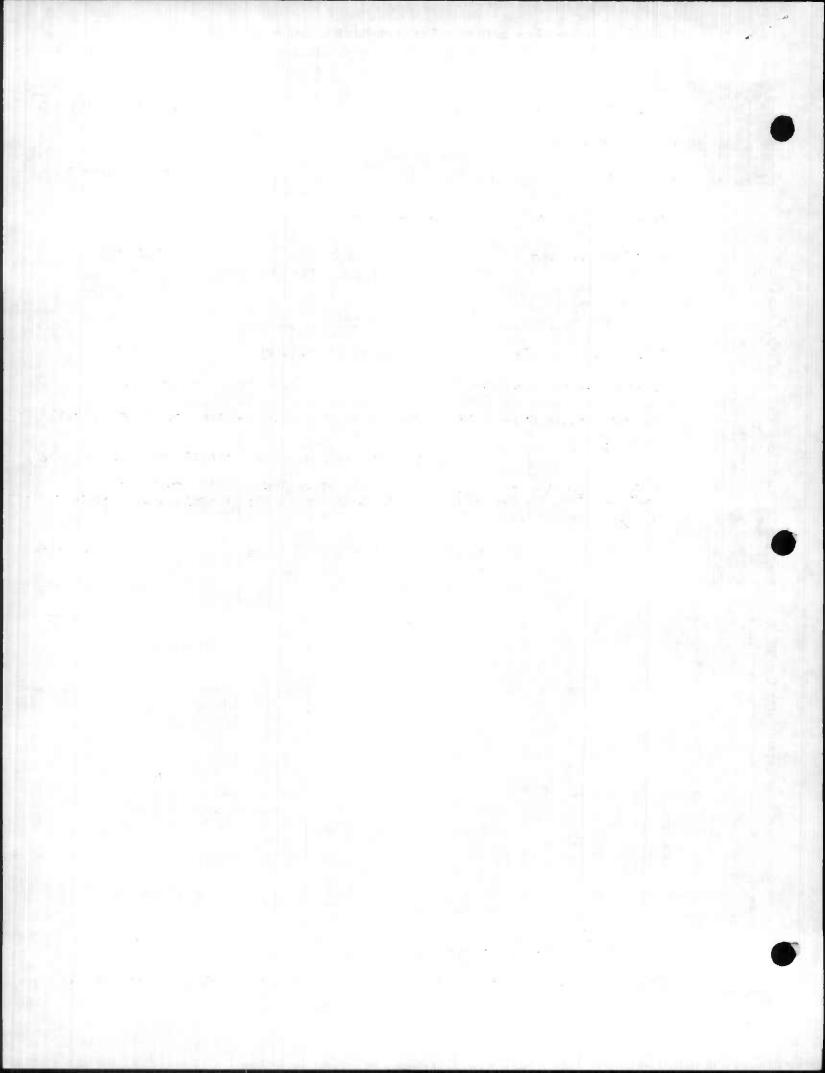
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Nama (First Middle Lest) 2. Data of Death 3. Time of Death **Physician** March 13, 1999 Dr. William Carter Stone, Jr. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown 8919 Liberty Road | Months | Days | Hours | Min. | 8. Date of Sirth (Month, Dey, Year) | Jan. 26, 1 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 1**X**M 2□ F Months Yrs. 1915 Maryland 84 Director 252-46-6833 Usual Rasidance of Dacedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yas 2 No Baltimore Randallstown Maryland Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with United States 21133 8919 Liberty Road deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, to Medical Example. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Eiamantary/Secondary (0-12) Collega (1-4or 5+) Dentistry Doctor of Denistry 12th Grade 18. Mother's Name (First, Middle, Maidan Sumame) 17. Father's Name (First, Middla, Last) Anna Medicine Warfield William Carter Stone, Sr. 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 8919 Liberty Road; Randallstown, Maryland 21133 Mrs. Doris Marie Stone - Wife 20b. Place of Disposition (Nama of camatery, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Kramation 3 Ramoval from State Baltimore/Washington Crem. 3/16/99 Laurel, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funarai Sarvice Licensae 22. Nama and Addrass of Fecility Loring Byers Funeral Directors, Inc. Randallstown, Maryland 21133 8728 Liberty Road; Approximate Interval Batween Onset and Deeth tha disease, or complications that caused the art failura. List only one cause on aach lina a daath. Do not antar tha mode of dying, such as cerdiac or raspiratory arrest, **Physician** /Medical Immediate Ceuse (Final · Congestive Heart Failure diseese or condition rasulting in daath) Examine Dua to (or as a consequance of): Examiner Emphysema ettending physician end for use es the buriel-transit lew requires that the death certificate be executed Sequantially list conditions, if any, leading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, arcinoma Physician/Medical thet initieted avents resulting in daath) Last signed by the e 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown à 24b. Wara autopsy findings available prior fo should t Completed 24a. Was an autopsy completion of causa of death? s certificate hes b director, page 2 s The 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Physician: director, Be 25. Was cesa rafarrad to medicel 26. Placa of Daath (Check only ona) 1 Yas 2 No Othar: 4☐ Nursing Homa 5 (Residence 6 ☐ Othar (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) funerei 27. Mannar of Daath 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After or Attanding 1 Natural 5 ☐ Panding 1 ☐ Yas 2 ☐ No eftar deeth. 2 Accidant invastigation Director: / 6 Could not be datarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 I Homicida Euneral Dire
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 Funeral Dire Hospital 29a. Cartifian 1/2 Certifying Physician: To the best of my knowledga, daath occurred et tha time, date end plece, end due to tha causa(s) and mannar es steted. edical To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certified Deput 30. Name and address of parson who completed cause of death (Itam 23a) (Type, Print) MD Shock Trauma 22 S. Greene, Batt. Md 2120 PHILIP MILITELLO 31. Data filed (Month, Day, Yaar) 32. Registrer's Signature State

DHMH 16 Rav 6/95

Registrar

MAR 1 7 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1999 Bruce Frederick Smith 11 8:00 PM March 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore 6419 Murray Hill Rd. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Year | if Under 24 Hrs. 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days Hours 215-58-1316 Yrs. Maryland July 8, 1951 47 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 21212 6419 Murray Hill Rd. United States 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American indien, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 X Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) industrial construction general contractor 18. Mother's Name (First, Middle, Maiden Surname) Katherine Eva Schroeder Gordon LeRoy Smith, Sr.

17. Father's Name (First, Middle, Last)

Physician

/Medical

Examiner

10e. Stete

10e. Street and Number

11. Meritei Status

Directo

Funeral

by

Completed

Funeral

Director

7 is marked other than "nature!", or itema 23s or 28s-f show traumatic event, the Marical Examinar maint be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or them 23a any Injury or other traumatic event, the Medical Experimental 2008.

Physician

/Medical

Examiner

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After

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Ne Hospital or Attending P in 24 hours after death. Ne Funeral Director: After t

page 2 certificate hes

50

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Physician:

Examiner

Physician/Medical

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Completed

Be

2

Certification:

edical

Maryland 21215-0020

Baltimore,

the Meryland

with

19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Smith/wife 6419 Murray Hill Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Baltimore, MD 20c. Location - City or Town, State

1 Burial 2 XCremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 21. Signature of Funeral Service Licensee

3/13/99 Baltimore, Maryland 22. Name and Address of Fecility Mitchell-Wiedefeld Home, Inc.

a. ; Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line.

6500 York Rd. Baltimore, MD

Immediate Ceuse (Final disease or condition resulting in death)

(evgces Due to (of es a consequence of)

Interval Between Onset and Deeth 1.54

Approximate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

2 No 1 ☐ Yes

26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

I	25. Was case referred to medica examiner?
J	1 ☐ Yes 2 ☑ No
1	27. Manner of Death

Hospital: 1 Inpatient 28e. Dete of Injury (Month, Day Year) 5 Pending investigation

6 ☐ Could not be determined

2 ER/Outpetient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 PNatural

2 Accident

3 Suicide

4 Homleide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) end menner stated.

29b. Signature and Ne of certifier

John Eppler, M.D.

29c. License number

29d. Date signed (Month, Day, Year)

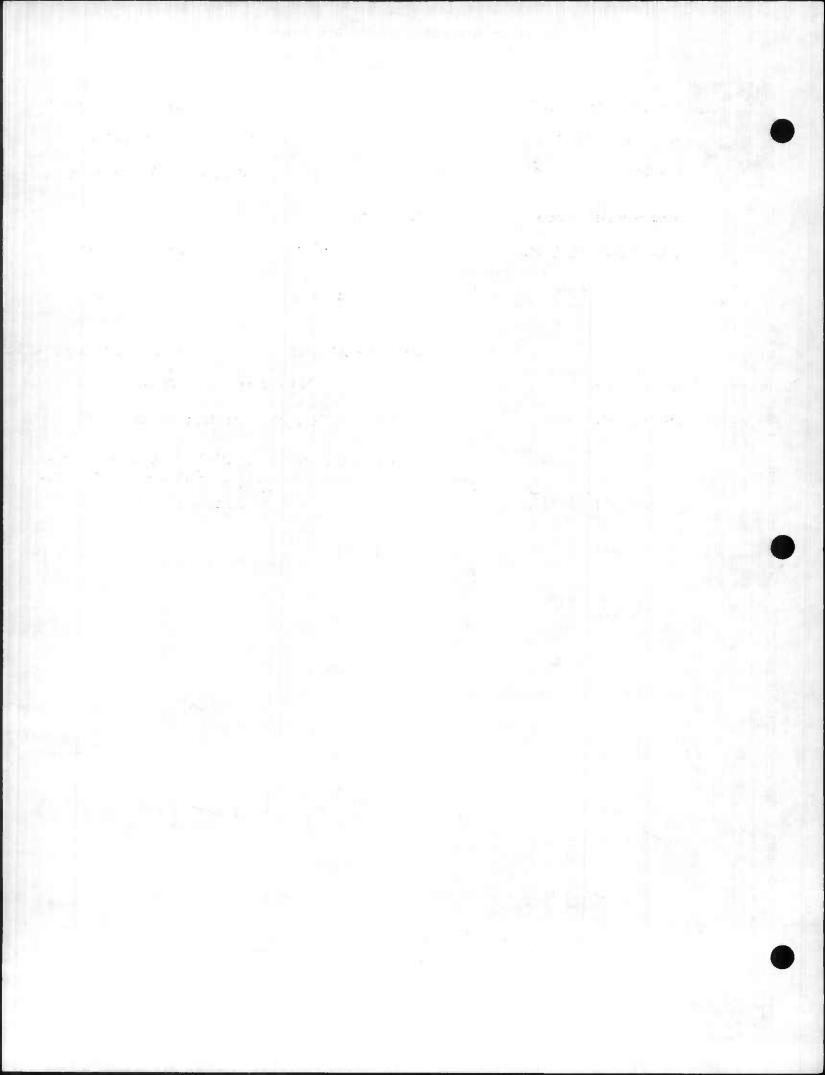
30. Neme end eddress of person who completed cault of death (Item 23e) (Type, Print) 120 Sister Pierre Dr., Suite #507

Towson, MD 21204

Registrar

31. Date filed (Month, Day, Year) MAR 1 6 1999

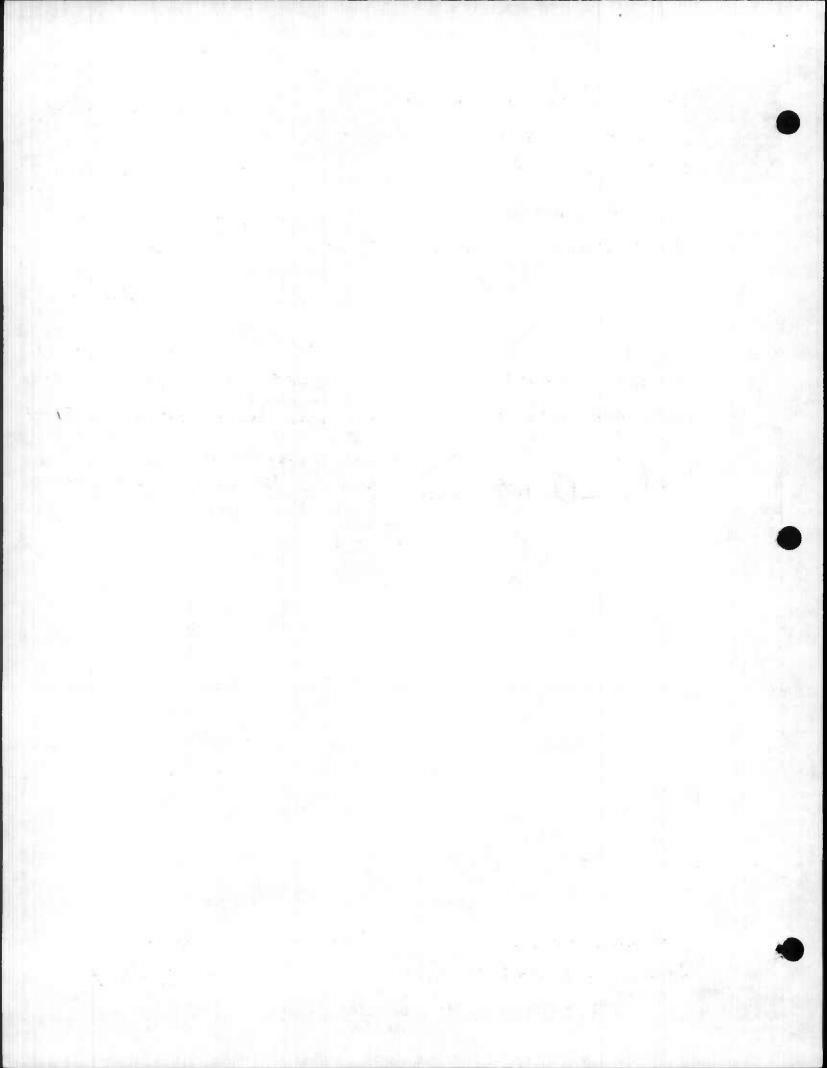




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State of Maryland / Department of Health and Mental Hygiene 9 9

Physician /Medical ETHEL VIRGINIA SMITH 6. Fecility Neme (If not institution, give street and number) BUE POINT N. H. 4b. City, Town, or Location of Deeth 2525 W. BELVEDENE AVE BATIMENE 5. Social Security Number 219 16 9351 1 M 2 F 82 Yrs. Months Deys Hours Min. Month, Dey, Year) County Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City L			Decedent's Name (First, Middle, Les	t)	Certii	ficate of	Death	1	Reg. No.		. 7
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2. Social Security Number 2. I Law April 1. April 1. The City Number 1. April 1. Apr	Examir	ier	2525 W. BEL	VEDERE	AV	E	BALTIME	NE	4c. County		4
So State 100 Carry 100 C			219 16 9351	X 7. Age (In yrs.	- M			8. Dete of Birth. Month, De	h y, Year) -1916		
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Sequential part Sequential	other other	e Co			3-17-0		18. Mother's Na		Meiden Sumem	e)	/
23. Signature of Conditions (Specify) 24. Disconsisting of Furnisal Service Legenses 25. Signature of Furnisal Service Legenses 26. Signature of Furnisal Service Legenses 27. Signature of Furnisal Service Legenses 28. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Pert I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 29. Disease of conditions. 29. Pert I, Enter the disease, or complications that caused the death. 29. Disease of conditions. 29. Disease of co	Menta arked	To			1			•			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#1 perPhy G769 3/18/99 EW Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year Mirco Mirco Stamenov 25, Feb. 1999 8:00p.m. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Ctr. Genesis Elder Care If Under 1 Year Baltimore Multi-Medical 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number Min. Days Months 100 M 2□ F Hours 91 097-36-1161 Dec.21,1907 Bulgaria Usuel Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Maryland N/A 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 741 E. Lake Avenue 21212 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, Whita, etc. 11 Marital Status 1 Navar Marriad 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) New York City Elementery/Secondary (0-12) College (1-4or 5+) Accountant Government 4 years 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gurga Unknown Marco Stamenov 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) t9a. Informant's Name/Relationship (Type, Print) 629 Camelot Drive, Bel Air, MD. 21015 Marco Stamenov (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 \(\tilde{\text{ZBurial}} \) 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) St. Demetrios Cemetery 3/1/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Nama and Addrass of Facility Schimunek Funeral Home of Bel Air, Inc. Brian Willem 21014 MD. 610 W. MacPhail Rd., Bel Air, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumothorax disease or condition resulting in death) hours Due to (or as a consequenca of): hours Puncture of Pleural Cavity Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure Cerebrovascular Accident 24b. Were autopsy findings available prior to 24a. Was an eutopsy completion of causa of death? Parotitis 1 Yes 2 No 1 Tyes 2 No 26. Place of Death (Check only one)

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permit. Page Depertment of Important: If any Injury or

altimore, Maryland 21215-0020

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

1 Nes 2 No 27. Manner of Death

5 Pending investigation 1 QNaturel 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide

29a. Certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of injury 28e. Dete of Injury (Month, Dey Year) 2/25/99

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28c. Injury et Work? 1 ☐ Yes 2 No

Other: 4 X Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 28d. Describe how Injury occurred

28d. Describe how Injury occurred Attempted Centralvenous Line Placement 28. Location (Street and Number or Rural Route Number,

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Treater Baltimore Medical Center St. Coation (Street and Number or Rural Route Number, City or Town, Steele 701 N. Charles Center St. Townson, Maryland Towson, Maryland 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s)

29b. Signature and title of certifier

29c. Licensa number OC ME

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greater

and manner stated.

THEODORE Mikin 31. Date filed (Month, Day, Year)

MAR 1 7 1999

32. Registrar's Signature

State Registrar

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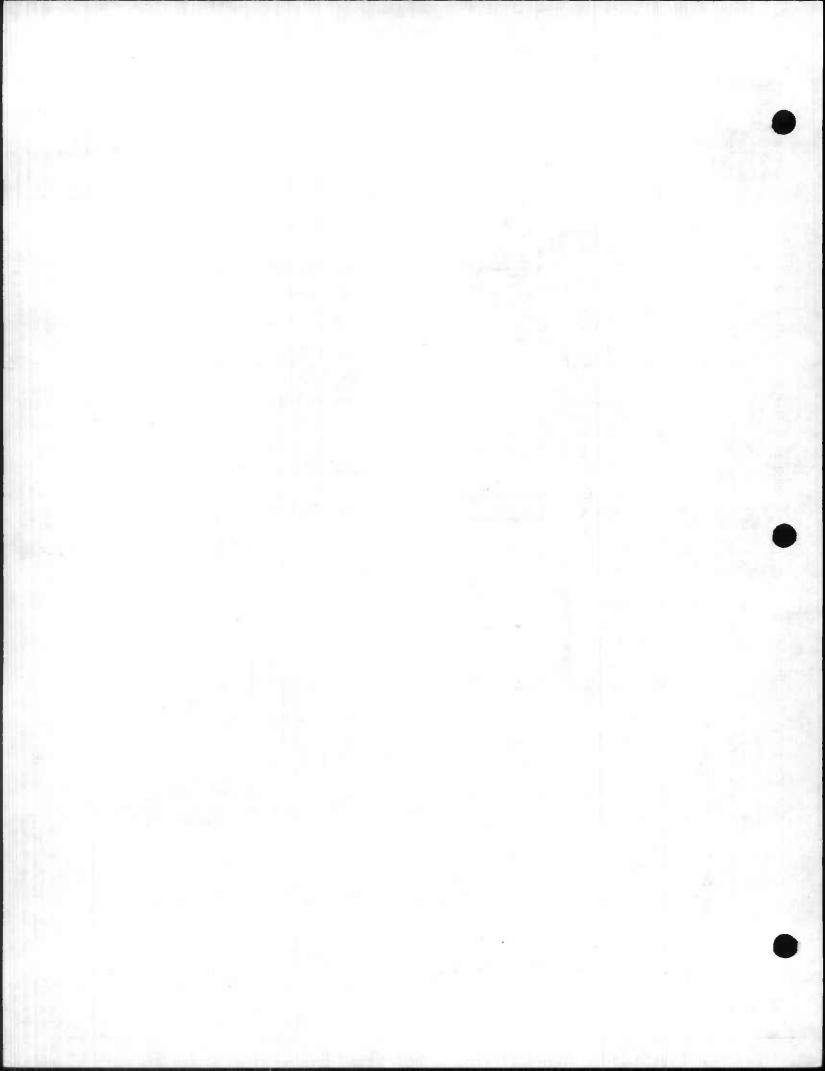
State of Maryland / Department of Health and Mental Hygienen

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Salvatore J. Salmeri March 12, 1999 1:40 a.m. /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 120 Lexington Road Bel Air Harford If Under 24 Hrs. ff Under 1 Year 8. Data of Birth (Month, Dey, Year) Oct. 4, 1922 5. Sociel Security Number Birthplece (State or Foreign
 Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1∭M 2□F Yrs. 76 Maruland Director 215-14-9420 Usual Residence of Decedent with the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 23a or 28a-f ahow the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Lexington Road 21014 U.S.A. Funeral death flems. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours effact Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ender of the free permitted other than "ender the permitted other than "ender the permitted other than "ender the permitted other than "ender the permitted other than "ender the permitted other than "ender the permitted other than "ender the permitted other than "ender the permitted of the permitted other than "ender the permitted 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Sales Representative Meat Company 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Joseph Salmeri Annie Lusco 19a. Informent's Name/Retationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) Mrs. Mary Salmeri (Wife) 120 Lexington Road. Bel Air, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Parkwood Cemetery 3/15/99 Baltimore. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air Inc.
610 W. Macphail Road, Bel Air, Maryland 21014 21. Signature of Funeral Service Licensee Buan a. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** OID LEUKEMIA /Medical Immediate Causa (Final ear disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): pue attending physician for use as the burie Physician/Medical the th Due to (or as a consequence of): certificate has been signed by the a lirector, page 2 should be detached if Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings aveileble prior to Be Completed 24a. Was an autopsy performed? completion of cause NA 1 Yas 2 No 1 ☐ Yas 2 ☐ No Attending Physicien: funaral director, 25. Wes case refarred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 5 Pending invastigation 1 Neturat To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 29a, Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) and manner stated. Medical 29c. License number 29d. Data signed (Month, Dey, Year) 3/12/99 AUSO OF CLOSE OF CONTESS OF THE CONTESS OF THE CONTESS OF THE PROPERTY OF THE ORIVE, 30. Neme and address of person who completed MADHU CHAUDHRY 31. Dete fited (Month, Day, Year) 32. Registrar's Signature State MAR 17

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Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 2 Per PHY FilmG769 3-17-99 rja Certificate of Death 30 1 Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Death Month **Physician** -18 Pm 1999 TINGLEY JR. Januar LELAND BENTLEY /Medical 4b. City, Town, or Location of Deefh 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Westminster Carroll Carroll County | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | 10/5/1916 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Funeral Months **™** M 2□ F Yrs. 301-07-2303 82 Pennsylvania **Director** Usual Rasidanca of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. fnslde City Limits 28a-f show f is marked other than "naturel", or frems 23s or 28s-f show traumstic event, the Modical Examiner must be notified at 1 Yes 2 No Jarrettsville Directo Md. Harford 10e. Streef end Number 10f. Zip Code 10g. Citizen of What Country? 21084 1213 Baldwin Mill Road U.S.A. Funeral 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Caucasian Specify É 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.)
Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natu any hijury or other traumatic event, the Medical 2008. Collega (1-4or 5+) Elementary/Secondary (0-12) 12 Aircraft Parts Inspector 17. Fethar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Bentley Leland Tingley Sr. Lena Ives 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 19a. Informant's Name/Ralationship (Type, Print) 346 North Tannery Rd. Beatrice A. Tingley/Wife Westminster, Md. 20b. Plece of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition Burial 2 Cremation 3 Removel from Stete 1999 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Air Mem. Gardens 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility E.G. Kurtz & Son Funeral Home, P.A. Aladden Jarrettsville, Maryland 23a. Pert1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one causa on aech in a. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in deeth) Three WKS Examiner Due to (or es e consaguenca of): Examine physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disaase or Injury that initieted evants resulting in death) Lest Dua to (or es e consequença of) Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. à 1 Yes 2 No 3 Probably 4 Unknown g 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed 2725. on twitis mporal 2 No certificate 25. Was casa referred to medical axeminar? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) OL this funeral 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Day Year) After Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deat Funeral Director: 6 Could nof be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicida ŏ 29a. Certifier 🌠 Certifying Physicien: To the best of my knowledge, death occurred et tha fima, date and plece, end due to the cause(s) end menner es stated. edical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) and manner stated. within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nema end eddress of person who complated cause of deeth (Item 23e) (Type, Print) Westminster, m1) Ave. DOAITE 200 memorial 31. Data filad (Month, Day, Year) 32. Registrar's Signeture FEB 4 1999 Registrar

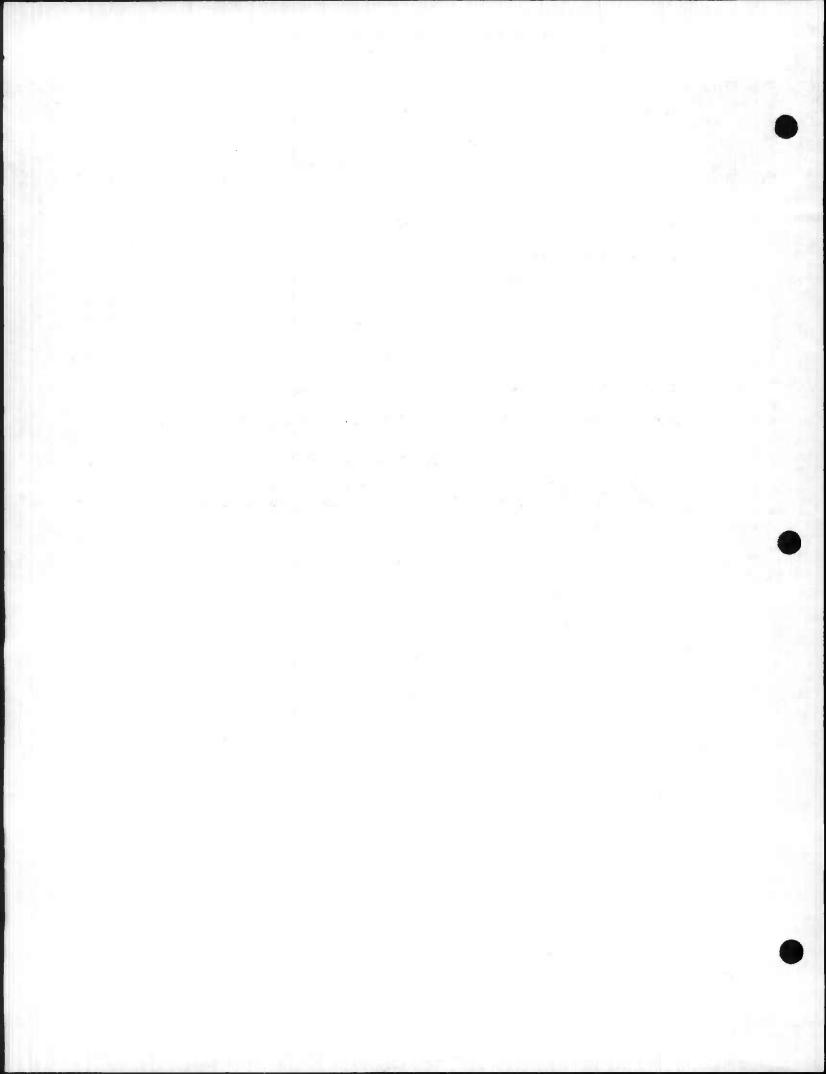
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Departmentimportant: any Injury		4 □ Donetion 5 □ Other (Special Signature of Funeral Sarvice Line	**	Mead			ial Park		Elk Rid		aryland
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g physician and as the burial-transit	an/Medical Examiner	resulting In death) Sequentially list conditions, if eny, leading to immediate ceusa. Enter Underlying Ceuse (Disease or injury that Initiated events resulting In death) Last	b. Cd	Due to (or each	s e consequ	ence of):	accio	dent			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death 12:25 pm FLORENCE E. VINCE 1999 MARCH 12 4a Facility Name (If not Institution, giva street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A Sinai Hospital BALTINOCR 8. Date of Birth (Month, Day, Year) 1-5-31 if Undar 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foraign Country) 1 M 2 F Days Months Hours Min 68 218-26-5673 Yrs. MD. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4011 BATEMAN AVE. 21216 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Stetus Black, Whita, etc. 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: BLACK 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DIRECTOR CHILD CARE -12-18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Neme (First, Middla, Last) LAMERTINE WILLIAMS MORIAH MOORE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PAUL VINCE (SON) 417 HARDMORE CT. GLEN BURNIE, MD 21061 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from State 3-16-99 WOODLAWN CEMETERY BALTIMORE, MARYLAND 4 Donetion 5 Other (Specify) 22. Name and Address of Fecility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses CFSP 1721-27 N. MONROE ST. BALTIMORE, MD 21217 with Ikell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) primay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avents Due to (or es a consequenca of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Aremia 24e. Was en eutopsy 24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 200 1 Anpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28e. Date of Injury (Month, Day Year) 27. Menger of Dea 28d. Describe how injury occurred 28c. Injury et Work? 28b. Time of 5 Pending investigation Natural 2 Accident 1 Yas 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

attending physician end for use as the buriel-transit The law requires that the death certificate be executed Box 68760 ed by the a signed by to Division of Vital Records, been : certificata has Physician: this funeral After t Attending death. i Director: A illed in by eitar 6 To the Hospital within 24 hours e To the Funeral Completaly filled

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

Q

Completed

r than "natural", or items 23s or 28s-f shorted standard at the Medical Examiner must be notified at

e filed within 72 hours efter death vall Hygiena.

permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic avent 2008.

Physician

/Medical Examiner

Physician/Medical Examiner

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Completed

Be

P

Certification:

edical

29e. Certifier

(Check only one)

altimore, Maryland 21215-0020

10

State Registrar

29b. Signature and title of certifiar whi mo 29c. Licansa number

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the best of axaminetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner statad.

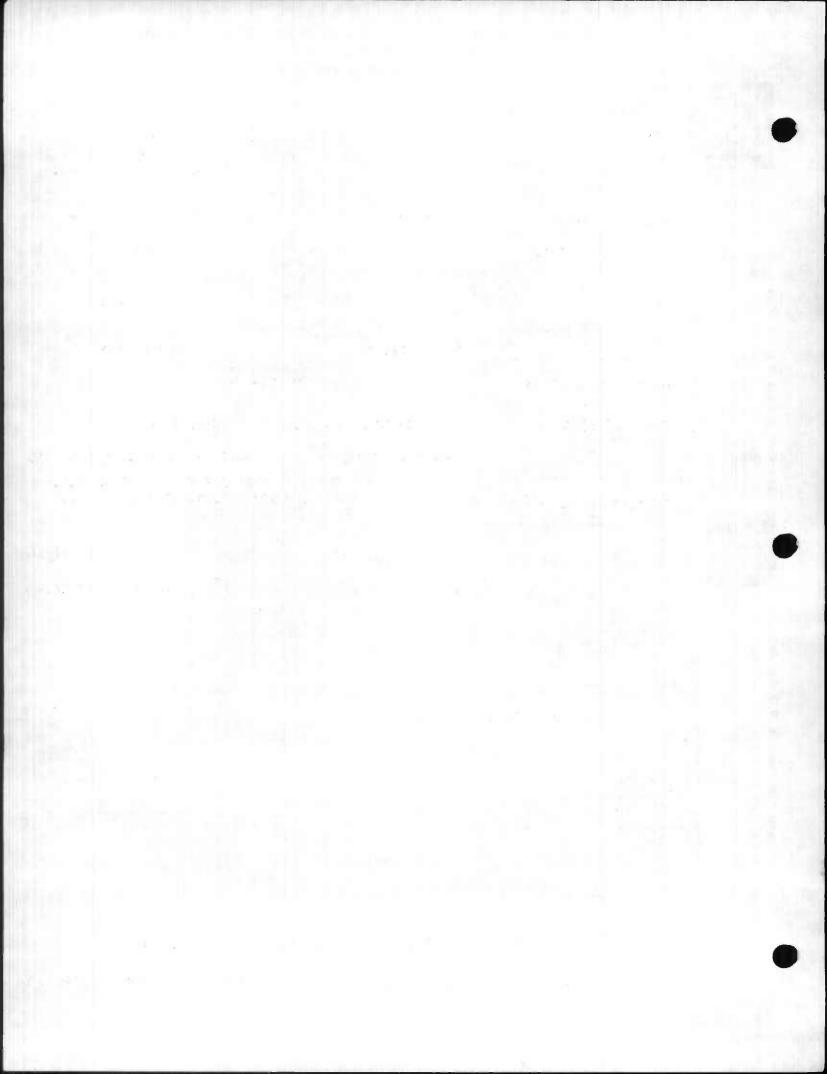
29d. Data signed (Month, Day, Year)

30. Nama end address of person who completed cause of death (Item 23a) (Type, Print)

2435 ucille

W. Belvedore Ave., Baltimore, MDZRIS

31. Date filed (Month, Dey, Year) 32. Regiŝtuar's Signature



Division of Vital Records,

signed b or Attending Physician: this efter deeth. Director: Aft 24 hours e Hospital

the Maryle

Baltimore, Maryland 21215-0020

To the Hospi within 24 hou To the Funer completely fil

29e. Certifier

(Check only one)

edical

29b. Signeture end title of certifier

M. D.

29c. License number

Pl. e #815

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Day, Year)

Bolto Md 21202

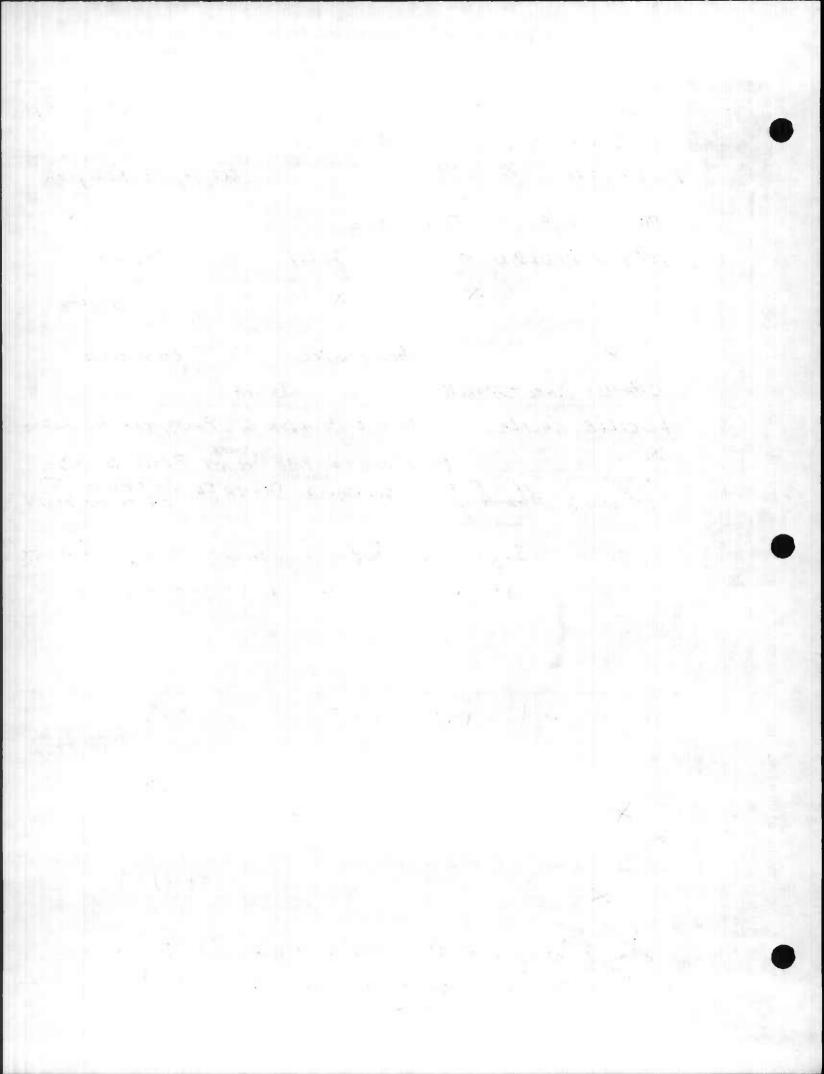
3/16/

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

E. Granzer 301 UIJ

31. Dete filed (Month, Day, Year) 32. Registrar's Signeture

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month 3:34 AM George F. Weber March 16 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nema (If not institution, give street and number) Baltimore HOSPITA Singi If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) If Undar 1 Yaar 5. Social Security Number 6. 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Days 1 XM 2 ☐ F Yrs 73 March9, 1926 Maryland 219-10-2538 Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Maryland Baltimore Woodlawn 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 3140 Jeffland Road 21244 United States 12. Was Dacedant Evar in U.S. Armed Forces? 1 NYas 2 □ No 1944 IYas, Giva Year or Datas: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Ricen, atc.) 14. Race - Amarican Indian, 11. Marital Status Bleck, Whita, etc. 1 Navar Marriad 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elamentery/Secondery (0-12) Collega (1-4or 5+) 2+ Government Recreational Director 18. Mothar's Name (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) George Henry Weber Mamie Schaub 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Bette M. Hopf / Sister Dove Court Arbutus, Maryland 21227 20b. Plece of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, Steta 20a. Mathod of Disposition Data Buriel 2 Cremetion 3 Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Loundon Park Cemetery 3/19/99 Baltimore, Md. 21. Signature of Funarai Sarvice Licensee 22. Nema end Address of Facility Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Rd. Maryland 23a. Part1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Maryland 21227 Approximata Intervel Between Onsat and Death Immadiata Causa (Final Preumonio disaesa or condition resulting in deeth) Dua to (or es a consequance of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Due to (or es e consequance of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not rasulting in the undarfying ceusa givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performad? complation of cause of death? 2 1 No 1 ☐ Yas 2 ☐ No 1 Yas 25. Was cesa referred to medical 26. Pieca of Deeth (Check only ona) examinar? Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 1 Nnpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Mannar of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

The law requires that the death certificate be axecuted physician end the burial-transit Division of Vital Records, P.O. Box 68760, 88 USB ó signed by the a After this certificate hes funeral director, page 2 or Attending Physician: death.

Physician

Examiner

Funeral

Director

item 27 is marked other than "naturel", or items 23s or 25s-4 show other trsumetic event, the Medical Examinan must be notified at

Pages 1 and 2 should be filed within 72 hours efter death nant of Heeith and Mentel Hygiena.

Department of Heeith e important: If Item 27 Is eny injury or other treu

Physician /Medical

Examiner

Examiner

Physician/Medical

py

Completed

Certification: To

Medical

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(Check only one)

29b. Signatura end titla of certifia

31. Data filed (Month, Day, Yaar)

29a. Cartifian

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Funeral

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1 24 hours efter death e Funeral Director: / Hospital To the Hosp within 24 hos To the Fune completaly fi

> State Registrar

30. Neme end eddress of person who complated ceusa of daath (Itam 23e) (Type, Print)

29c. Licensa number

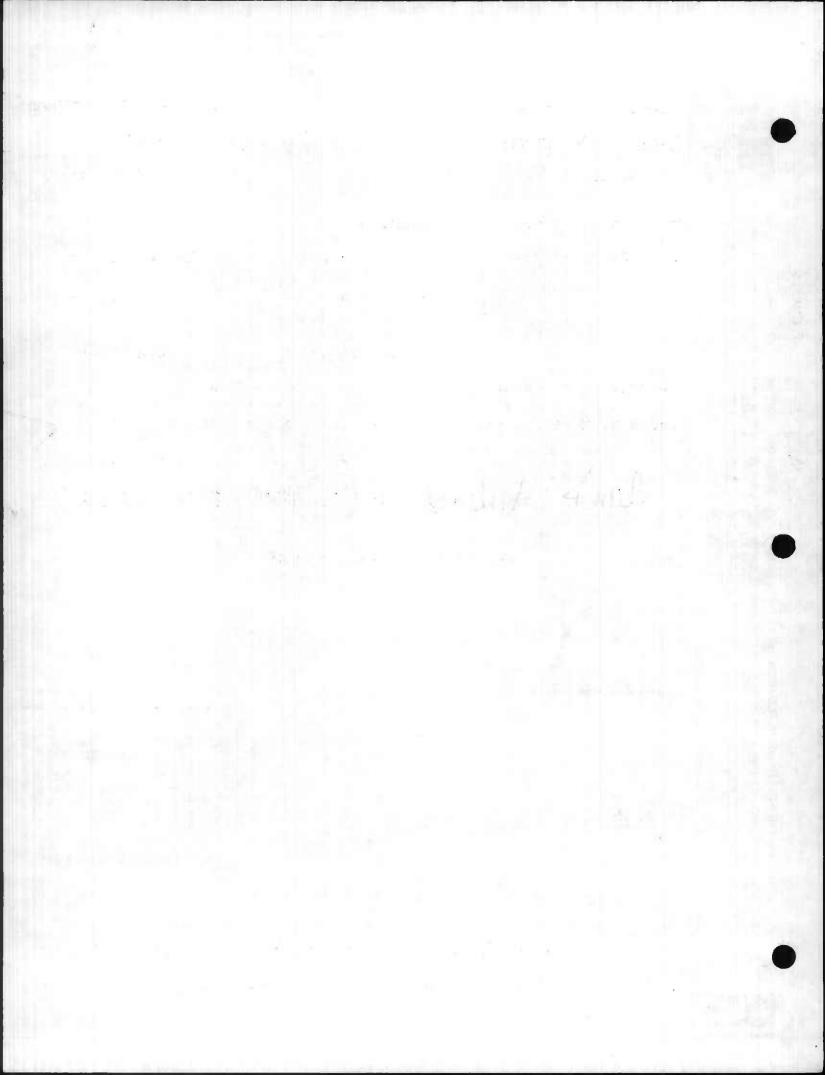
TS Cartifying Physicien: To the best of my knowledga, daath occurred at tha tima, data end place, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end dua to tha ceusa(s) and mannar statad. 29d. Data signad (Month, Day, Year)

Hock Belvedere Avenue Boltimore MD 21215 2401 West

32. Registrar's Signatura

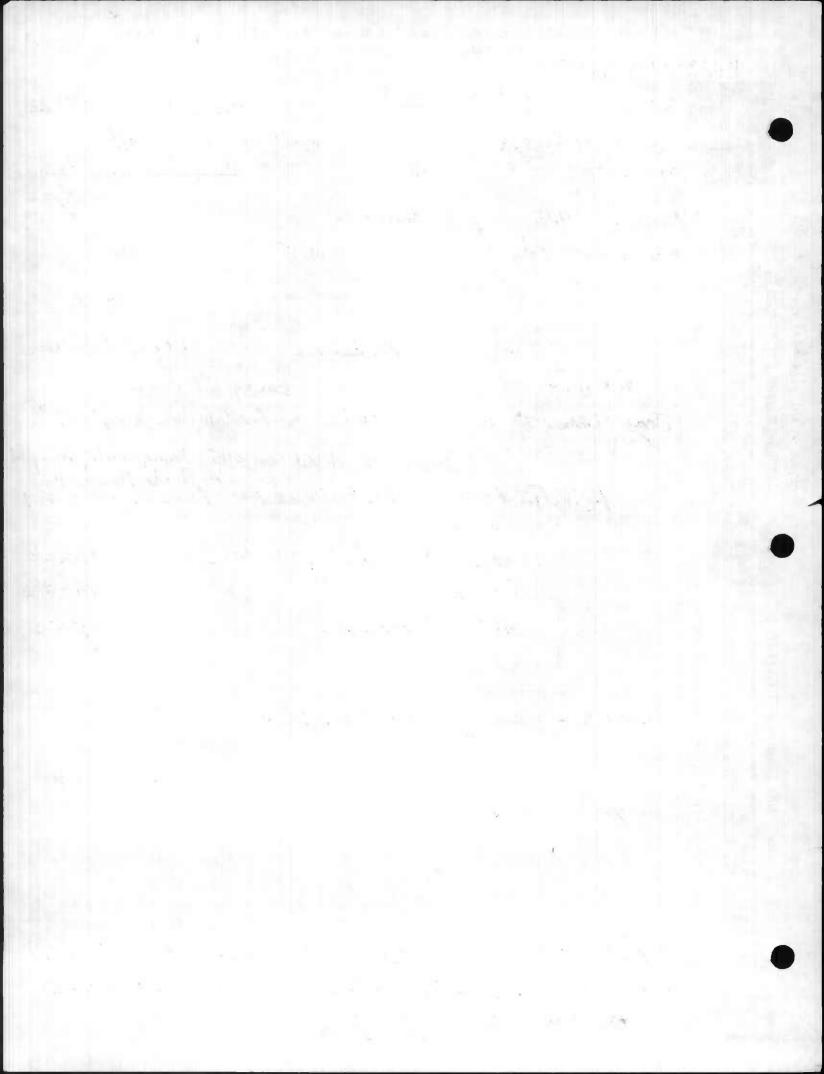
DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 🏻 🗬 Item 1 Per PHY FilmG769 3-17-99 Item#8 perFH G769 3/10/99 EW Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death James M. Wommack, March **Physician** 722 Wommack James /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOS hmore neu If Under 24 Hrs. 8. Data of Birth 6-16-28 5. Social Security Number
244-50-4934
Usual Rasidanca of Decedant 9. Birthpleca (State or Foreign Country) If Under 1 Year 7. Aga (In yrs. last birthday) **Funeral** Days Months 70 Yrs. 15M 2DF Cardina Director North the Merylend 10d. Insida Offy Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Baltimore 1 Yas 2 No Funeral Director Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with unoun as Junes Warmack 5713 21215 WA Surset 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yes 2 No Specify: Yas, Giva Specify: Blace þ 3 Widowad 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Hygiena. Elementery/Secondery (0-12) Collega (1-4or 5+) City of Baltimore Maintenance 7 is marked other traumatic svent, to 18. Mothar's Name (First, Middle, Maiden Surneme) 17. Fathar's Nama (First, Middle, Last) Be 2 should be fi Womnac wknown Enily Pages 1 end 2 should 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Burat Route Number, City or Town, Stete, Zip Code) Millstor Wommack-son or other tra ando 15town Jones Baltimore, 20a. Mathod of Disposition 20c. Location - City of Town, Stata 20b. Place of Disposition (Name of Data cemetary, crematory or other place) 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 3/15 Mills Maryland Important: any injury o 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility, Bostima 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final Week disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner 1085 physician and s the buriel-transit the death certificate be executed Sequentially tist conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceuse (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a cons Division of Vital Records, P.O. Box 68760, Oho Physician/Medical Dua to (or as a con iquanca of for use es signed by the a 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown gastrointestinal bleeds by 24b. Wara autopsy findings eveiteble prior to should I 24a. Was an autopsy performed? Completed comptation of causa of daath? his certificate hes bal director, page 2 s 1 Yas 2 No 1 ☐ Yas 2 No Be 25. Was cesa rafarrad to medicel axaminar? 26. Place of Daath (Check only one) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To this 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Hospital or Attending P
 24 hours after death.
 Funeral Director: After t 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifian 30. Nama and address of parson who completed ceusa of death (Itam 23e) (Type, Print) 270 Belvedere Bultimore, MD Dawn 31. Data filad (Month, Day, Ragistrer's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death MARCH 6:17 AM JUNE O. WILSON 15, 1999 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death 4101 GRANITE AVENUE BALTIMORE If Undar 24 Hrs. If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1□M 28F 68 214-26-5251 Yrs. MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MARYLAND N/A 1 BYes 2 □ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? UNITED STATES OF AMERICA 4101 GRANITE AVENUE 21206 12. Was Decedenf Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, afc.) 14. Raca - Amarican Indian, 11 Marital Status Black, White, etc. 1 Naver Married 2 Married 1 ☐ Yas 2 ☑ No if Yes, Give Yaar or Dates: 1 Yes 2 No Specify: Specify: WHITE 3 ₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOME 6TH GRADE HOMEMAKER N/A 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) LUCILLE A. PLACK CHARLES LANCASTER 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 GRANITE AVENUE/BALTIMORE, MARYLAND 21206 ROBERT WILSON, JR 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State GREENMOUNT CREMATORY MAR. 18, 1999 BALTIMORE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funeral Sarvice Licensee 6009 HARFORD ROAD ALTENBURG FUNERAL HOME, P.A. BALTIMORE, MD. 21214 M00612 Honald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) ulmonan. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last RTE ORONARY Dua fo (or as a consequence of) 23b. Dfd tobacco use contribute to the cause of death? brillation Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an eutopsy completion of cause of death? 1 Yas 25. Was case refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ fnpatienf 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residenca 6 □Other (Specify)

Physician /Medical Examiner

that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

natural, or harm 23a or 28a-f the Medical Examiner must be notif

Hygiene.

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Pages 1 and 2 should

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Baltimore, Maryland 21215-0020

Examiner burial-transit Physician/Medical eu signed by i à Completed director, Be Medical Certification: To n 24 hours after death we Funeral Director: / pletely filled in by the f

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After

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To the Hosp within 24 hor To the Fune completely fi

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 28a. Date of fnjury (Month, Day Year) 27. Manner of Deat 1 Natural

28d. Describe how injury occurred 28b. Time of

28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Pleca of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

4 | Homicide

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

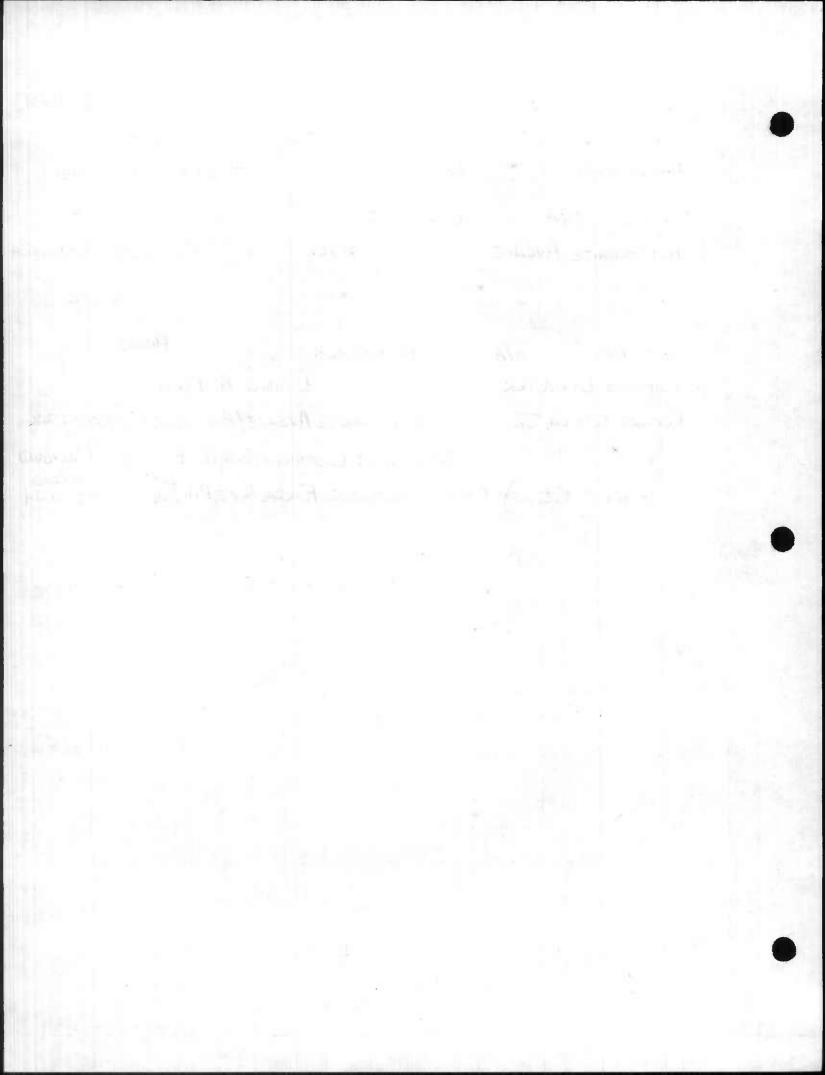
MD 30. Name and of person who complated cause of death (Item 23a) (Type, Print) an 3400 0001 MO

Baltimore Brehms Lane

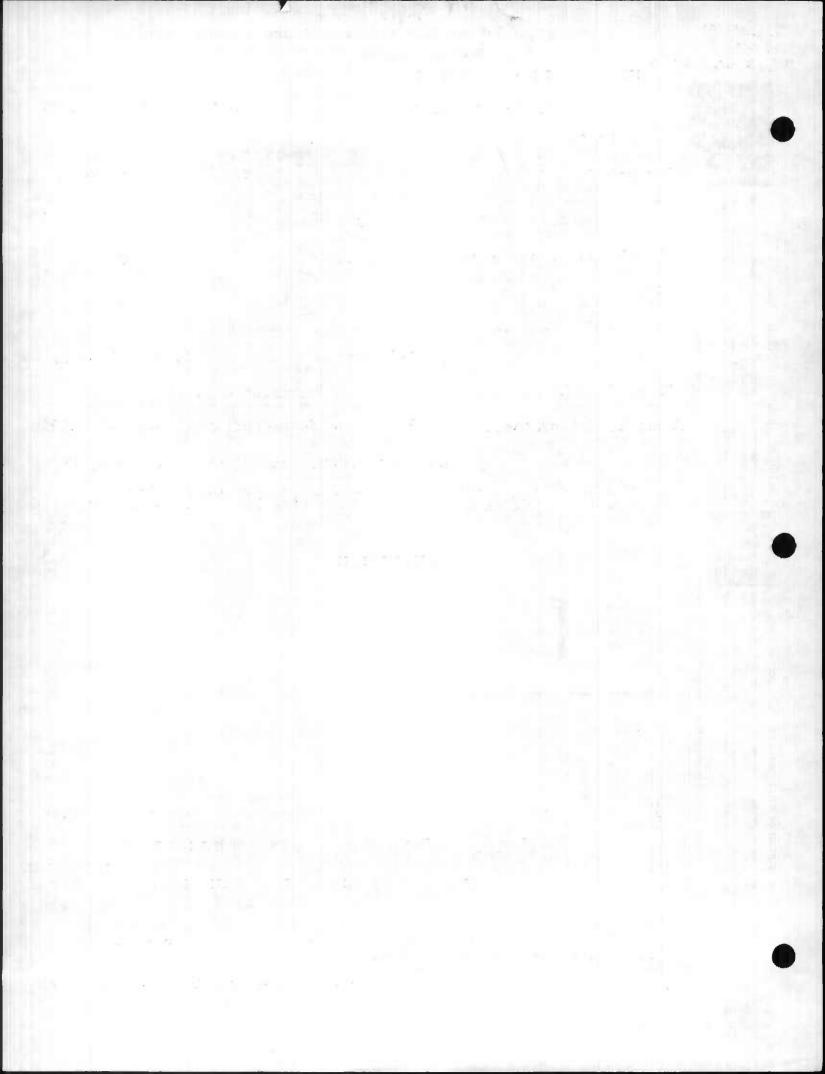
State Registrar

DHMH 16 Rev 6/95

MAR 17 1999



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	Examiner	4e Fecility Neme (If not institution, given 3450 WILKENS	BALTIMORE		4c. County of Deeth N / A						
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	f show	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location MD Howard Columbia								. Inside City Limits 1 ☐ Yes 🏖 No	
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	el', or items 23 Example: must by Funeral	11. Maritel Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Detes:	ver in U,S. 1	3. Was Decedent of h		ecify Yes or No- Rican, etc.)	14. Race Bleck	American k, White, etc		
Baltimore, Maryland 21215-0020 semit. Peges 1 end 2 should be filed within 72 hours ef	- 4	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	+) life	cedent's Usuel Occupive kind of work done a. DO NOT use retired	pation during most of work d)		16b. Kind of Bu			
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and and	ed out								9/		
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m Far	Important land	Edward A. Gregorchik Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228									
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68760, ifficete be executed	g physician end es the bunal-transit fedicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of):									
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<u>م</u> ۽	page page						1,22 Ye	s 2 No	1,000	Yes 2□ No	
/ita	s certificate director, pag	25. Wes case referred to medical exeminer?	11		law		th (Check only on	e)			
Jivision of or Attending Phy ifter death.	ifter death. Sirector: After this in by the funeral distribution or intification: To	1 XYes 2 No 27. Manner of Deeth 1 Naturel 5 Pending 2 Accident Investigatic 3 Suicide 6 Could not to determined	28e. Dete of Injur (Month, Dey Found: 3-15-90 28e. Plece of Injur building, etc	ry - At home, farm, (Specify)	e of A Wo 1 Street, fectory, office	ry et rk? Yes 2 No		NGESTED [reet and Numb n, State) 345	red DRUGS	SCENE Route Number, ENS AVENUE,	
	within 24 hours a To the Funeral I completely filled	29e. Certifier 1 Certifying Pi	hysician: To the best of miner: On the basis of end menner ste	f my knowledge, de examinetion end/or		me, dete end plece,		ause(s) end me			
To the	omple omple	29b. Signature end title of certifier	and manner ste		29c. Licens	se number	2	9d. Dete signed	d (Month, De	ey, Year)	
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	State	30. Name and eddress of person who Stephen S, Y2 31. Dete filed (Month, Dey, Yeer)	adentZ, 32. Registre		111 Per	nn Street	, Baltim	ore, Ma	ryland	d 21201	
	Registrar	MAR 1	1999	1320	D. pope	4631					



32. Ragistrar's Signetura

111 Penn Street, Baltimore, Maryland 21201

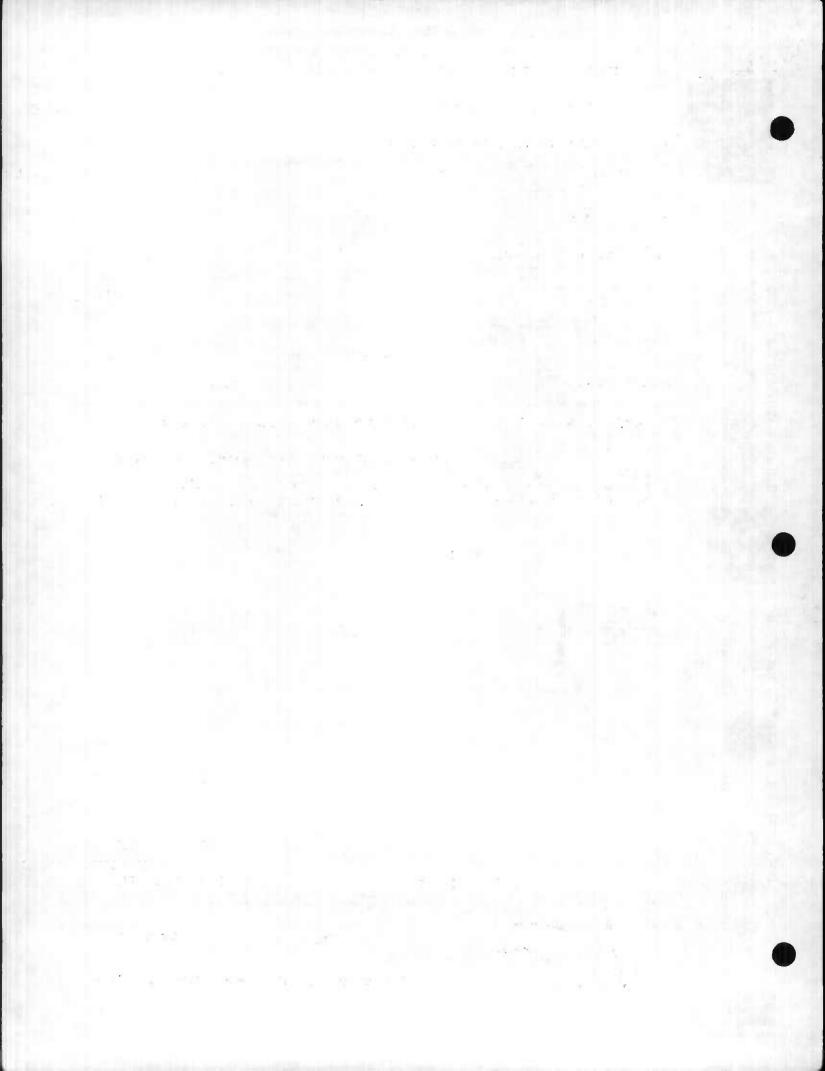
DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day,

MAR 1



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 1 999 Month MARCH **Physician** 4:25 P.M ESTELLE WATERS /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore Saint Joseph Medical Center Towson If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. lest birthdev) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Deys Months Hours 1□M 2□F New York Director 090-03-5444 3-18-1916 82 Usual Residenca of Decedent the Marylend 10e Stete 10b. County 10c. City. Town or Location 10d. inside City Limits Show rthan "natural", or itema 23a or 28a-f show the Medical Exempler must be notified at Maryland 1 TYPE 2X No Harford Jarrettsville Directo 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code with 21084 U. S. A. 1821 Midsummer Lane Funeral death Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status filed within 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed Department of Health and Mentel Hygis Important: If item 27 is marked other: any Injury or other traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Jennie Etta Horning Joseph Edward Biesser 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 1821 Midsummer Lane, Jarrettsville, Maryland Mrs Margaret W. Patten (Daughter) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Valley Mem. Gards 3-18-99 Timonium, Maryland 1X Burial 2 ☐ Cremation 3 ☐ Removel from Stete Dulaney 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. allace Looks, D 1050 York Road, Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** OBSTRUCTIVE JAUNDICE DUE TO MONTHS /Medical Immediete Cause (Finet disease or condition resulting in death) **Examiner** Due to (or es a consequença of): Examiner CARCINOMA OF THE GALL BLADDER Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest pue burial-tran Due to (or es a consequence of): The law requires that the death certificate be exec Box 68760. Physician/Medical the Due to (or es e consequence of) 88 use ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE signed i Records, by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy Completed peen OLD CEREBROVASCULAR ACCIDENT has page 2 1 Yes 2 No 1 ☐ Yes 2 🗓 No certificata Division of Vital Hospital or Attending Physician: director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: ¥☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No After this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1X Naturel s after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Ptaca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. edicai To the Hosp within 24 hou To the Funer completely fil 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number atividad D. de Lean 19508 m. D much 15, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 NATIVIDAD D. DELEON, M.D.,

10

State Registrar 31. Date filed (Month, Dey, Year)

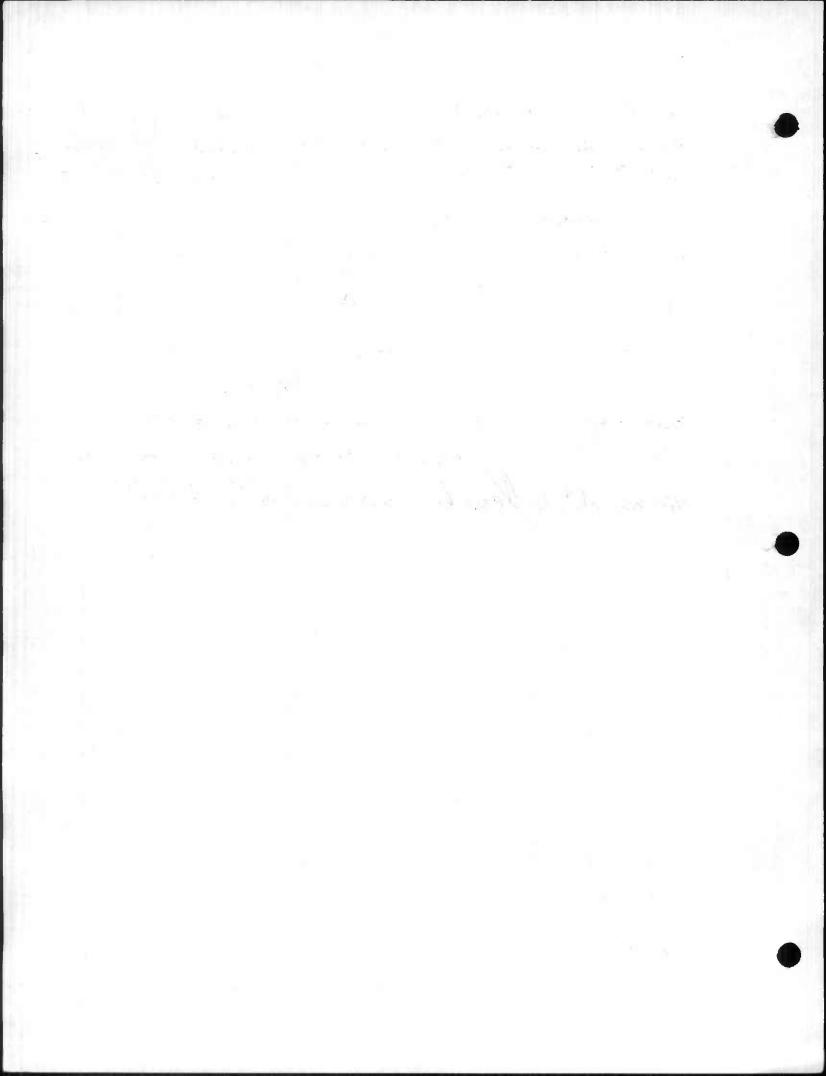
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32. Registrer's Signature

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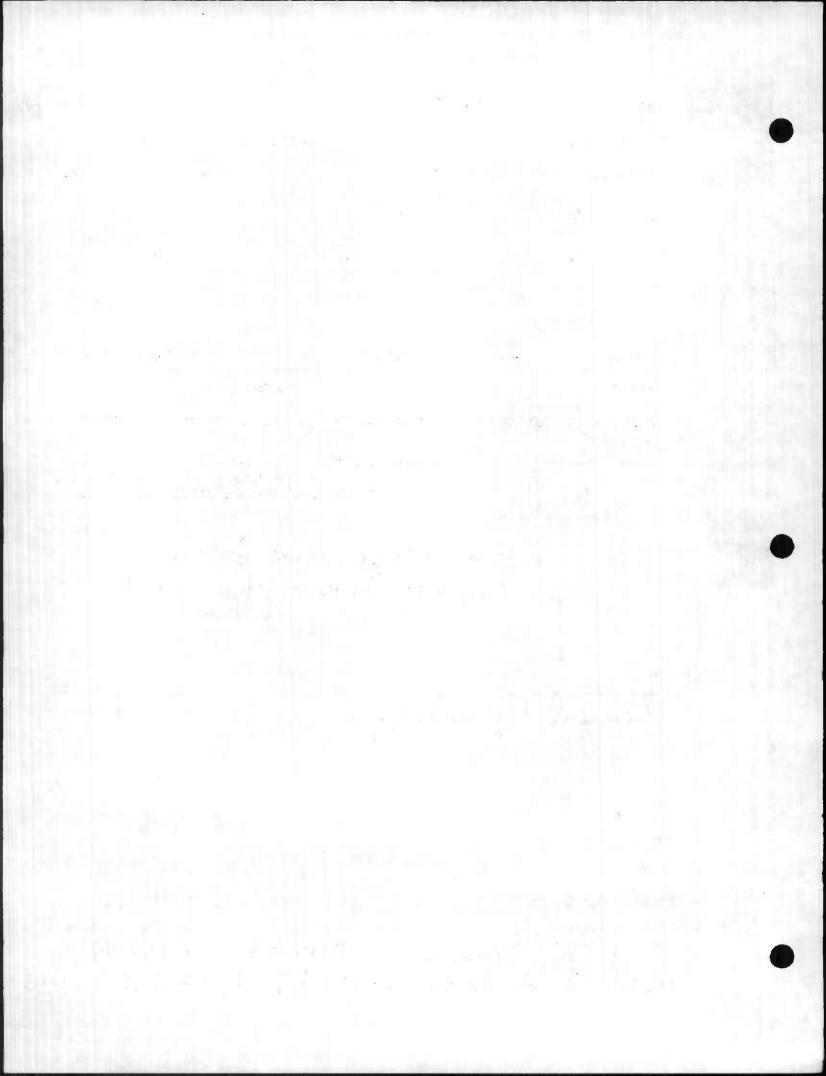
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State Stat	ita									26. Place of D		7221-						
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Pollack, M.D. Sog V.ES M.IIRd Rock.ile, Mod 20851 State 31. Date filed (Month, Day, Year) 32. Registrar'a Signeture					28a. Date of Injury (Month, Day)	Year) 2			28c. Injur Wor	y at k?	28d. Describe	e how Injury occur	red					
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth Month 3 **Physician** WRIGHT 2,00 MORRIS 16 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nema (If not institution, giva streat and number) Examiner 323 MASON CT. BALTIMORE N/A 6. Sax 1 M 2 □ F If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foraign Country) 7. Aga (In yrs. last birthday) 8. Deta of Birth **Funeral** Months Days Hours Min Yrs. 49 214-54-5395 2-10-50 MD. Director Usual Rasidanca of Decedant the Maryland 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits ir than "natural", or frame 23s or 28s-f show the Medical Exercitive trust to notified at MD. N/A BALTIMORE 1 X Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 323 MASON CT. 21231 USA deeth Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Rece - American Indian 11. Maritel Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nant of Haalth and Mental Hygiene.
Int: if Item 27 is marked other then "natural", or her iny or other traumatic event, in a Med call Executes. 1 ☐ Yas 2 🔯 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) -12--0-LABORER CONSTRUCTION 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) AARON WRIGHT LOUISE HOUSE 19a. informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) OPHELIA WRIGHT(SISTER) 8722 GROFFS MILL DR. OWINGS MILLS, MD 21117 20b. Place of Disposition (Neme of cemetery, cramatory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from Stata permit. Page Department of Important: if any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) ZION CEMETERY 3-17-99 BALTIMORE, MARYLAND 21. Signatura of Funaral Sarvica Licenses 22. Nama and Addrass of Facility PHILLIPS FUNERAL HOME. P.A. 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Part1. Entar tha disaasa, or complications that caused the death. shock, or heert failure. List only one ceusa on each line. Do not entar the mode of dying, such as cardiec or respiretory errest, Approximata Intarvel Betwean Onsat and Daath **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in daeth) Examiner Examine physician and s the bunel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated avents resulting in daeth) Last Division of Vital Records. P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) ettanding p ed by the datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No þ 24b. Wera autopsy findings evailable prior to 24e. Wes en autopsy performad? Completed peen : complation of cause of death? certificate has t irector, pega 2 s 2 No 2 No or Attending Physician: Be 25. Was case refarred to medical 26. Placa of Deeth (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) P 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury et 1 Netural 5 Panding 1 ☐ Yas 2 ☐ No invastigation death oftar death
Director: A 2 Accidant 6 Could not be determined 3 ☐ Sulcida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Ptace of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide hin 24 hours oft the Funeral Di npletaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medicai (Check only one) within 2 To the complet 29b. Signature and title 29c. Licansa number 29d. Data signad (Month, Day, Year) 30. Name end address of person who complated causa of death (Itam 23a) (Type, Print) 940 31. Data filed (Month, Day, Year) 32. Ragistrer's Signeture State Registrar MAR 1



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15, DAVID ELMER March 1999 3:00 A.M. WILLIS. Sr. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner White Marsh
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
March 21, 1 8314 Poplar Mill Road Baltimore Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Days 1₩ 2□F 219-10-9419 72 1926 Director Maryland Usual Residence of Decedent the Maryland 10a State 10c City Town or Location 10h Count 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified as 1 ☐ Yes 2 ☑ No Baltimore Maryland Director White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A.

14. Raca - American Indien,
Bleck, White, etc. 8314 Poplar Mill Road 21236 12. Wes Decedent Ever in U,S. Armed Forces? 1 10 Yes. 2 □ No If Yes, Give Year or Dates: 1944–46 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Merried Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman 12 years Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Elmer Willis Belle 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Evelyn Willis 8314 Poplar Mill Road (wife) White Marsh, Maryland 21236 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 3-16-99 Baltimore, Maryland 22. Name end Address of Fecility
Mitchell-Wiedefeld Home, Inc.
6500 York Road Baltimore, Maryland 21212 21. Signeture of Funeral Service Licensee 23a. Pert1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List collected on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel 2 Tres, disease or condition resulting in death) Examiner ician and burial-transit certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t, P.O. the datached signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? Deen pega 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific. Be 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? 28b. Time of Certification: 1 Avetural 5 Pending investigation 1 TYes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Medical 29a. Cartifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

State Registrar 6365

32 Registrar's Signature

N CHARLES

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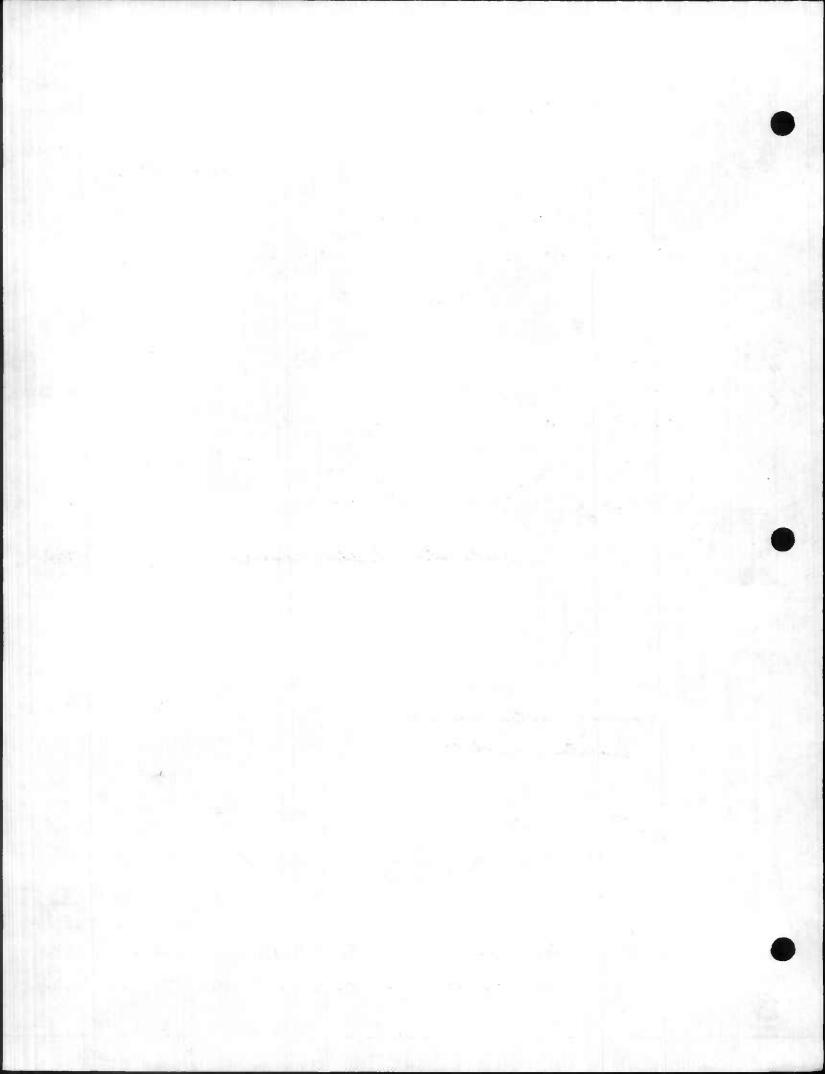
30, Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

ami

AMB H MERSE

MAR 1 6 1999

31. Date filed (Month, Day, Year)



Item	24a Per PHY FilmG76		*	epartment of I Certificate of			iene _{eg. No.} 99	08	1390	
Physician /Medical	Decedent's Name (First, Middle ESTHER	Q.	WINKELS	TEIN		2. Date of Death MARCH 10, 1999 7:25PM				
Examiner Funeral Director	4a English Name (Mant institution aim street endoughed)				4b. City, Town, or Lo BALTIMORE If Undar 24 Hrs. Hours Min.		BALTIM	ORE 9. Birthple	ce (Stata or Foreign	
2 .	Usual Rasidance of Decedent 10a. Stata 10b. County		10c City Town	or Location				100	1 foolds City Limits	
the Marylan 28a-f ahow nouthed rector									Yes 2 No	
\$ 0 A O	10e. Street and Number 11924 NEW COUN	NTRY LANE		10f. Zip Coda 21044	1		0g. Citizen of W	hat Country	y?	
020 ours after death v air, or terms 23s Example Train	11. Meritel Stetus 1 Nevar Married 2 Marr XXWidowed 4 Divorced	12. Wes Decedan Armed Forces ied 1 Yas 2 If Yas, Give Yaar or Datas	? kNo	13. Was Decedent of I If Yas, specify Cub 1 ☐ Yas 2 ☒ শo	an, Maxican, Puarto	ecify Yas or No- Rican, atc.)	Black	k, Whita, at	c.	
Maryland 21215-0020 d 2 should be filed within 72 hours after th and Mentel hygiene. T is marked other than "natural", or its traumatic avent, the Medical Examine To Be Completed by Fur	15. Deceden (Specify only higher Elementery/Secondary (0-12)		(Decedant's Usuel Occu Giva kind of work dona lifa. DO NOT use retire EMAKER	during most of work	ing	16b. KInd of Business/Industry OWN HOME			
aryland 212 should be filed with and Mentel Hyglene. marked other than matic avent, the II	17. Fether's Name (First, Middle, ISAAC	LEVCOV	TZ		18. Mother's Name	a (First, Middla, I	Maidan Sumame RESLEF			
	19a. Informant's Name/Relations LOUIS WINKELS			Meiling Address (Street 1924 NEW COL						
Peges nent of ant: If the ury or o	20a. Nethod of Disposition 1 Burial 2 Cramation 4 Donation 5 Other (5)		20b. Place of Comatery MENORAL	Disposition (Nama of cramatory or other plated GARDENS	3					
Balt permit. Depart import any inj once.	21. Signal of uneral Service	Bruser		22. Name end Addres	SOL TERSTOWN R	OAD-PIKE	ESVILLE,			
Physician /Medical Examiner	23a. Part Enter the disease, of shock or hear failure. Lat Immediate Ceuse (Finel disease or condition resulting in death)	a. ACUT	M.	OCARDIAL	NH9M				nterval Between Onset end Death	
OX 68760, notificate be executed anding physicien and use as the burishtransit in/Medical Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initieted avants rasulting in death) Last	c	Due to (or es e co							
Box (Beeth certiff estending for use at	D 4 11 O21 - 4 - 141 - 4 - 414					22b. Did tokango yan gontdhyte to the gayes of d			h	
ords, P.O. Box 6 requires that the deeth certificeen signed by the attending phould be deteched for use as	Part II. Other eigninicant condition	art II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I.						TIMORE 9. Birthplece (State or Foreign NEW YORK 10d. Inside City Limits Yes 2 No en of What Country? A. 4. Race - American Indian, Black, Whita, atc. Specify: WHITE d of Business/Industry HOME SUMME Town, State, Zip Code) MD. 21044 Pation - City or Town, State LAUDERDALE, FL. BROS. INC. LLE, MD. 21208 Approximate Interval Between Onset end Death MMS Approximate Interval Between On		
De Se Se Se Se Se Se Se Se Se Se Se Se Se						24a. Was a perform	performed? available prior to complation of cause			
= F # 6 0						1 🗆 Y	as 2/7 No	1 🗆	Yes 2□ No	
/ita	25. Was casa rafarred to medical examiner?	Hospital:		_ 0	26. Placa of Deat					
on of ding Phys. h. funeral di	1 Yas 2 No 27. Manner of Death 1 Neturel 5 Pandin 2 Accident investig	28a. Data of Inj (Month, D		me of ury 28c. tnju	4 Librarsing Ho	ome 5 Raside 28d. Dascribe h				
Division of the Hospital or Attending P. within 24 hours after deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Sulcide 6 Could determ	not be	281. Location (Street and Number or Rurel Route Number, City or Town, State)							
DIVI To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi		g Physician: To the best Examiner: On the basis of and manner s	of axamination and/							
To the withlift To the Comp	29b. Signature and title of Certifie	nshe,	NO	29c. Licen	S/40	2	9d. Data signed MARCH	(Month, D.) + / 3	ay, Year)	
CHI	30. Name and address of person 31. Data filed (Month, Day, Year)	truE, MP	death (Item 23a) (T	ype, Print)	HG. 1	Dre,	BAU	M	1 21215	
State Registrar	MAR 17	1999	we f	. Spark	2	·	¥	/		

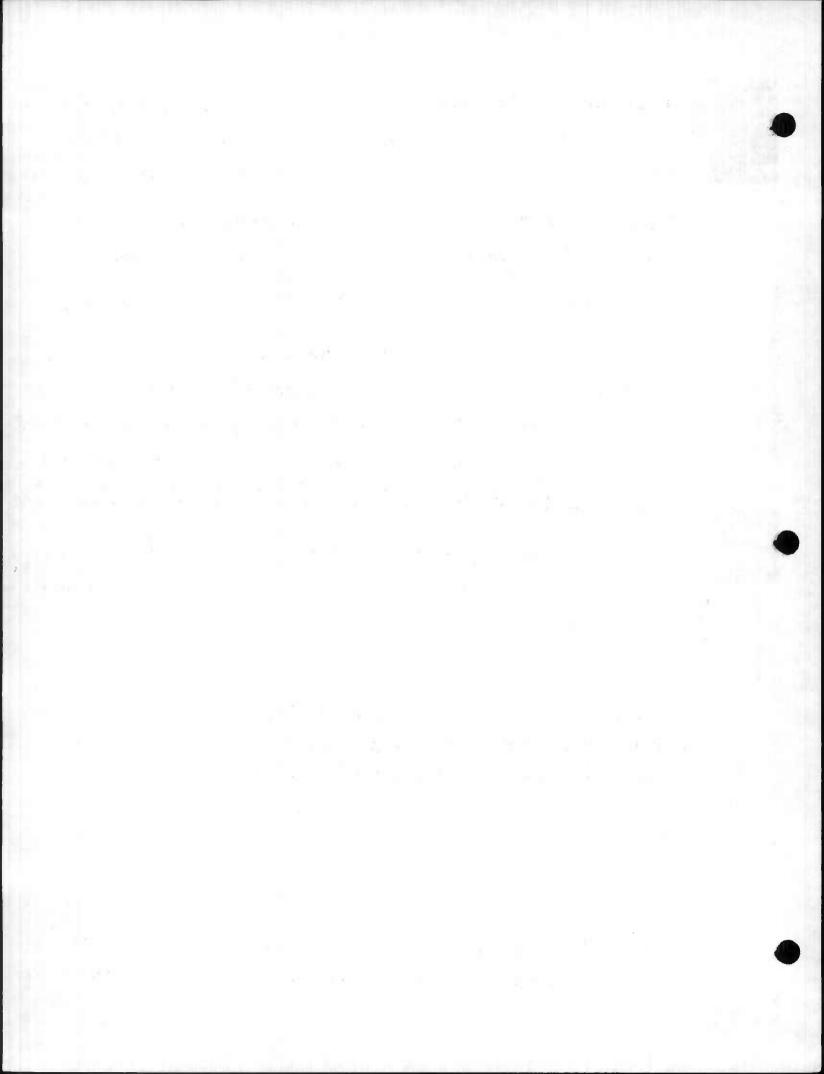
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death PRISCILLA MARCH -**Physician** WILLIAMS 10:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE UTURE ARE HOMEWOOD If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, 9. Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 213-14-296 1 □ M 2 K F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director BALTIMORE CIT 1 Yes 2 No MARYLAND 10e. Street and Number 10g. Citizen of Whet Country? 10f, Zip Code ŏ EXINGTON 2120 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Herns 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indien, Black, White, etc. 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours efter Department of Heelih and Mental Hygione. Important: If Itam 27 is marked other than "natural; or ite any injury or other traumatic event, I'm Medical Examine. 1 Never Married 2 Married 1 ☐ Yes 2 Z No if Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: by 3 Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) TOME MAKER OWN 12 THGRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EVI WALTER 2 CMN-UNKNOWN TERRIE SMITH DAUGHTER 1202 A, WE
20b. Place of Disposition (Name of cemetery, crematory or other place) 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Name of Date 20c. Location - City or Town, State 20e. Method of Disposition KING MEM. PARK CEME, 33-15-99 WOODLAWN, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility TO SEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTHORE, Mb. 212 BALTIMORE, Mb. 21217 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical PNEUMONIA · ASPIRATION DAY Examiner Due to (or as a consequence of) by Physician/Medical Examiner DAY STROKE physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Box 68760. the death certificate be Due to (or es a consequence of): P.0 Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DEPENDANT DIABETES MELLITYS INSULIN Records, 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy HYPERTENSIVE CARDIOVASCULAR DISEASE ISCHEMIC / CONGESTIVE CARDIOMYOPATHY - Yes SEVERE 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was cese referred to medicel exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending Investigation 1 Natural To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: After completely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 1 🕏 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stelled. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kamao le Dave D18362 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 3455, Wilkens Ave., Suite 308. Balto. Md 21229 KOMALK. DANG M.D.

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32. Registrer's Signature

Registrar

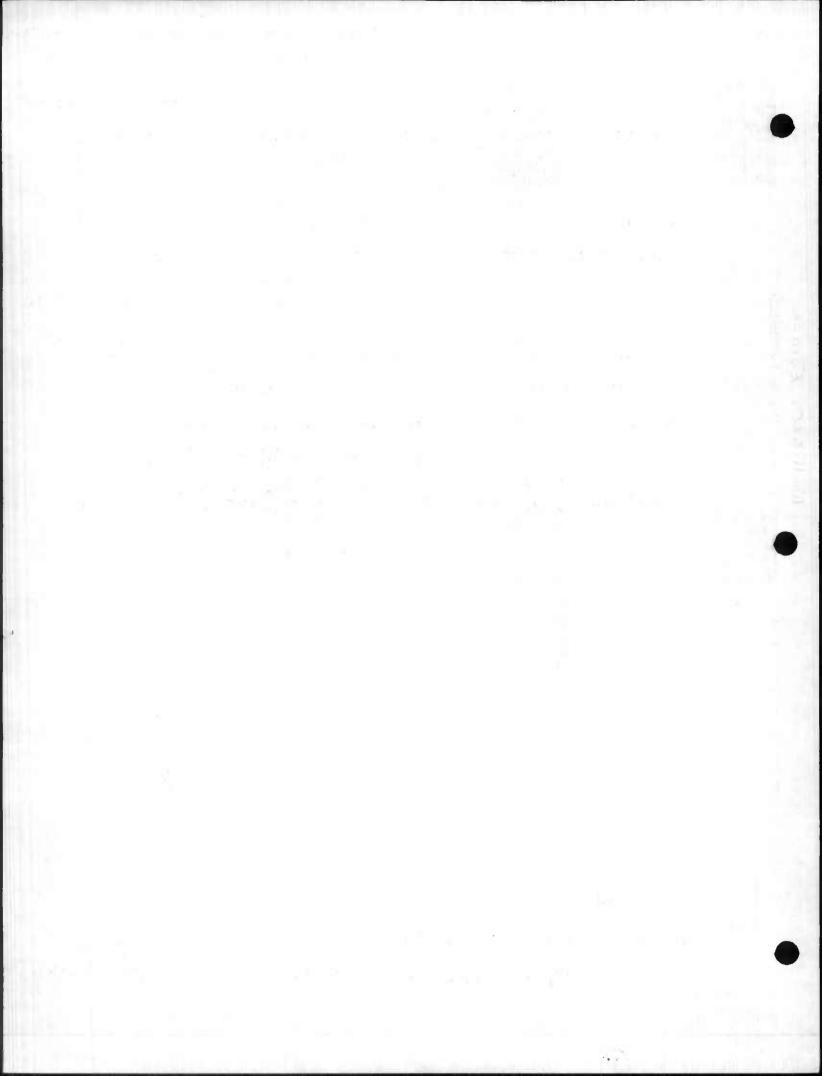


32. Registrar Signature

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

unice



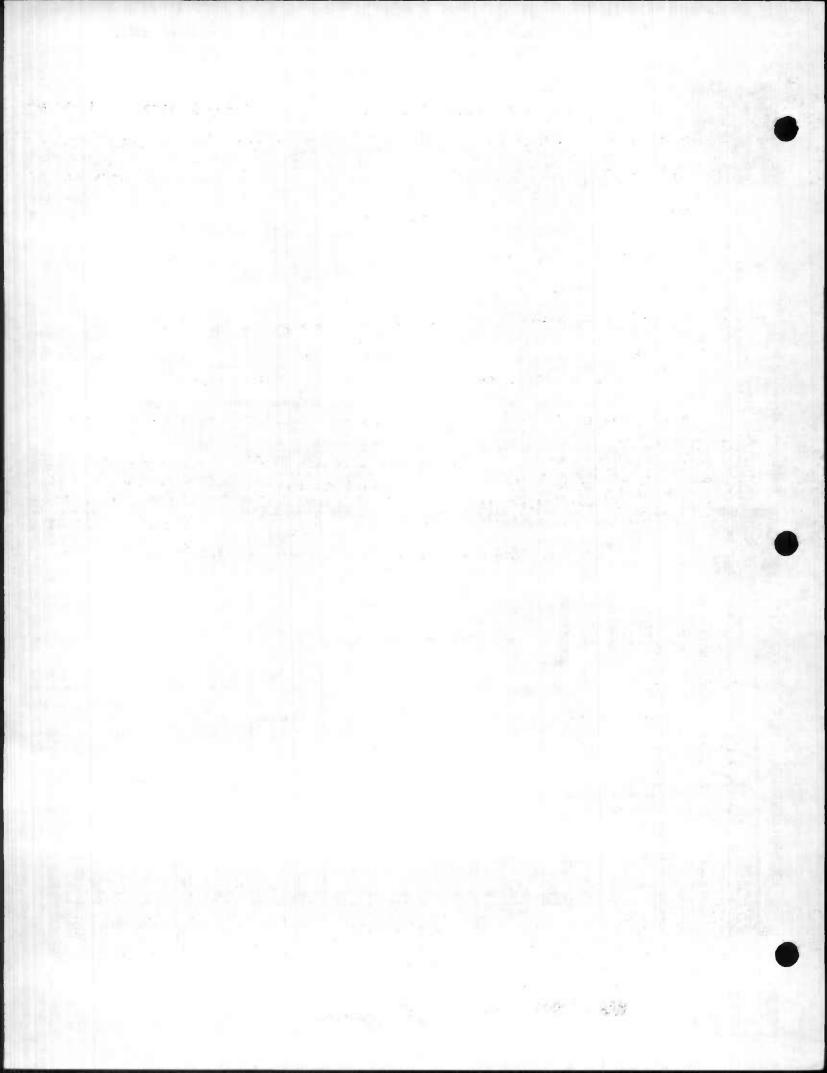
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Name (First, Middla, Last) **Physician** March 9, 10:50 AM 1999 Selbert Harold Zittrain * /Medical 4a Facility Nama (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 2000 Odell Avenue, 616 Apt. Baltimore If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 10 M 20 F Months Days Hours Min. Yrs. 219-28-5872 Director JUNE 26, 1931 Maryland Usuai Rasidanca of Decedant the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Y□ Yes 2□ No MD Director N/ABaltimore 10e. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? Ave., 2000 Odell USA Apt. 616 21237 death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No ff/Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian. Biack, White, atc. permit. Pages 1 end 2 should be filed within 72 hours efter tepoprimant of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or ther any injury or other treumatic event, the Medical Evantant 1 Navar Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2√ ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 Never Worked N/A 18. Mother's Neme (First, Middle, Maiden Sumema) 17. Fathar's Name (First, Middla, Last) Be Benjamin Zittrain Helen Fine 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Fred Fine/Uncle 2228 Poplar Grove St. Baltimore, MD 21216 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20e. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Metro Crematory, Inc. 3/16/99 Baltimore, MD 21. Signature of Fureral Service Lide 22. Name and Addrass of Facility elen ! Cremation Society of Maryland, Inc. Edward A// Gregorchik 299 Frederick Rd. Balti

23a. Part1. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21228 Approximate Intarvai Batween Onset end Death **Physician** Immadiata Cause (Final disaasa or condition rasulting in death) /Medical - sousmous cell concer (metastatu Examiner Due to (or es e consequence of) Examiner physician and the bunal-transit Sequantially list conditions, if any, leeding to immadiate cause. Enter Undarlying Ceusa (Diseese or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Box 68760. 90 Physician/Medical Dua to (or as a consequanca of) Ses usa Po 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by ti should be detach 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Ware autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 ☐ No certificate 25. Was casa rafarrad to medicat axaminar? Be 26. Plece of Deeth (Check only one) Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Assidance 6 ☐ Other (Specify) 1 Yas 2 No 10 After this funeral 27. Mannas of Deeth 28e. Dete of Injury (Month, Day Yaar) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: al or Atternary of the order. 1 Natural 5 Pending 1 Yes 2 No invastigation 2 Accidant in 24 house Funerel Direction of filled in by the 6 Could not ba 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stete) Hospital 29a, Certifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data end place, end due to the causa(s) and mannar as stated. edicai To the Hosp within 24 hor To the Fune complately fi 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. Licanse number 29b. Signature and titla of certifier Waterburg, M.D. 9559 30. Nama and addrass of person who complated causa th (Itam 23a) (Type, Print) 4940 EASTERN AUE. BALT. KD. 21224 CONTERBUR JHBAC 32. Aggistrar's Signatura

State Registrar

P.O.



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev **Physician** 11:35PM Nancy Caroline Zepp 13, 1999 March /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Catonsville Ball
Wunder 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year)
July 15, 1928 801 Hilltop Road 5. Social Security Number 6. S Baltimore If Under 1 Year Birthplace (State or Foreign MD Country) 7. Age (In yrs. last birthday) **Funeral** Deys Months 1□M 20 F 219-20-9676 70 Yrs. Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location "natural", or hams 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 801 Hilltop Road 21228 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marifel Status Bleck, White, etc. Med within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Nerried Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: White Specify: à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own HOme permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is manned other any Injury or other traument. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Griffin Garner Ethel Offutt 19a. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Earl P. Zepp, Jr. Husband 801 Hilltop Road, Catonsville, MD 21228 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Baltimore Washington Crem. 3/17/99 Laurel, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete fnterval Between Onset end Deeth **Physician** /Medical Immediale Cause (Finel a. End Stage (Myngeal disease or condition resulting in deeth) Examiner Examiner iclan and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the burial P.O. Box 68760 Physician/Medical Due to (or es e consequence of) USB BS signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by should should 24b. Were autopsy findings eveilable prior to 24e. Wes an eutopsy performed? completion of cause of death? page 2 s 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1□ Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending Neturel 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, deta and plece, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 3.15.99

State Registrar

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31. Date filed (Month, Dey, Year)

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32. Registrer's Signeture J. April 1

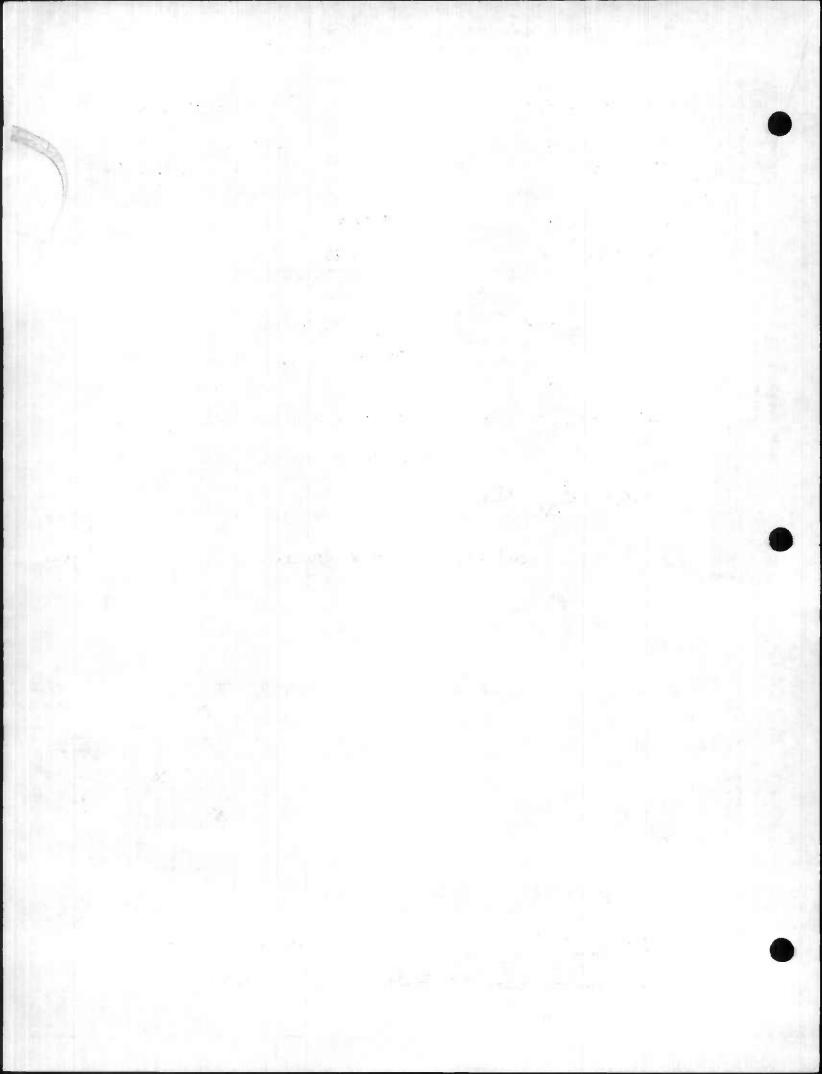
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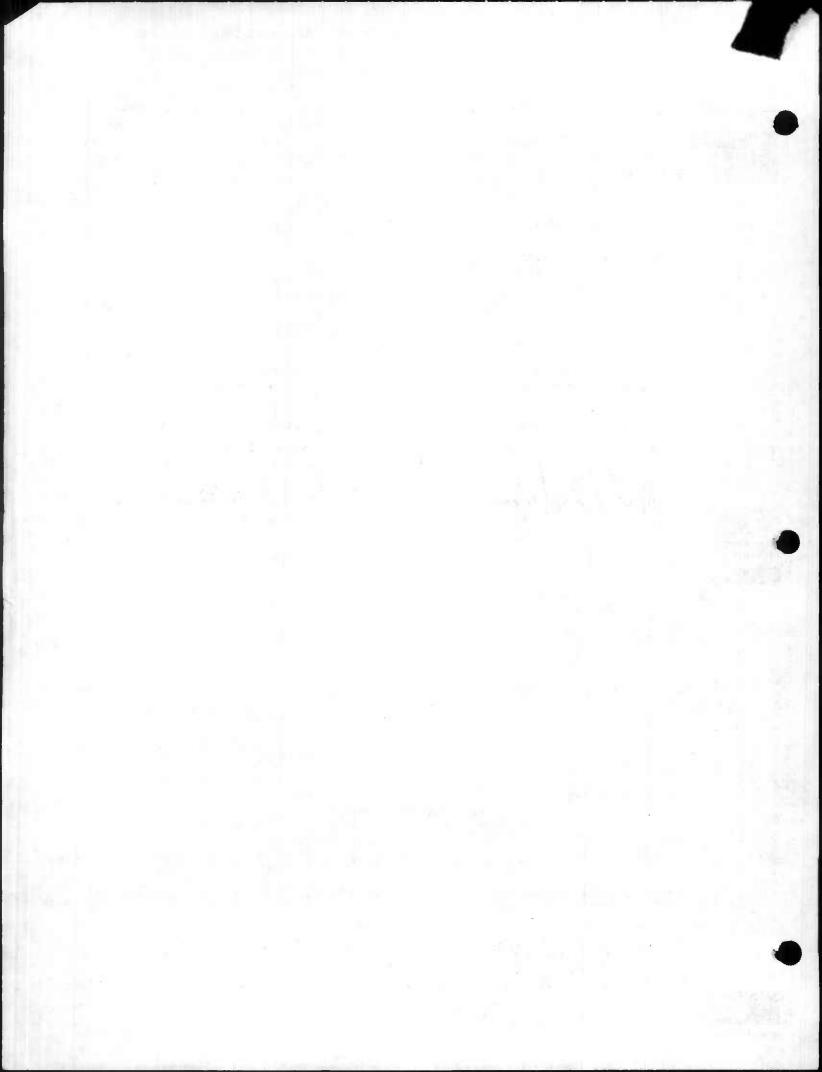
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30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)



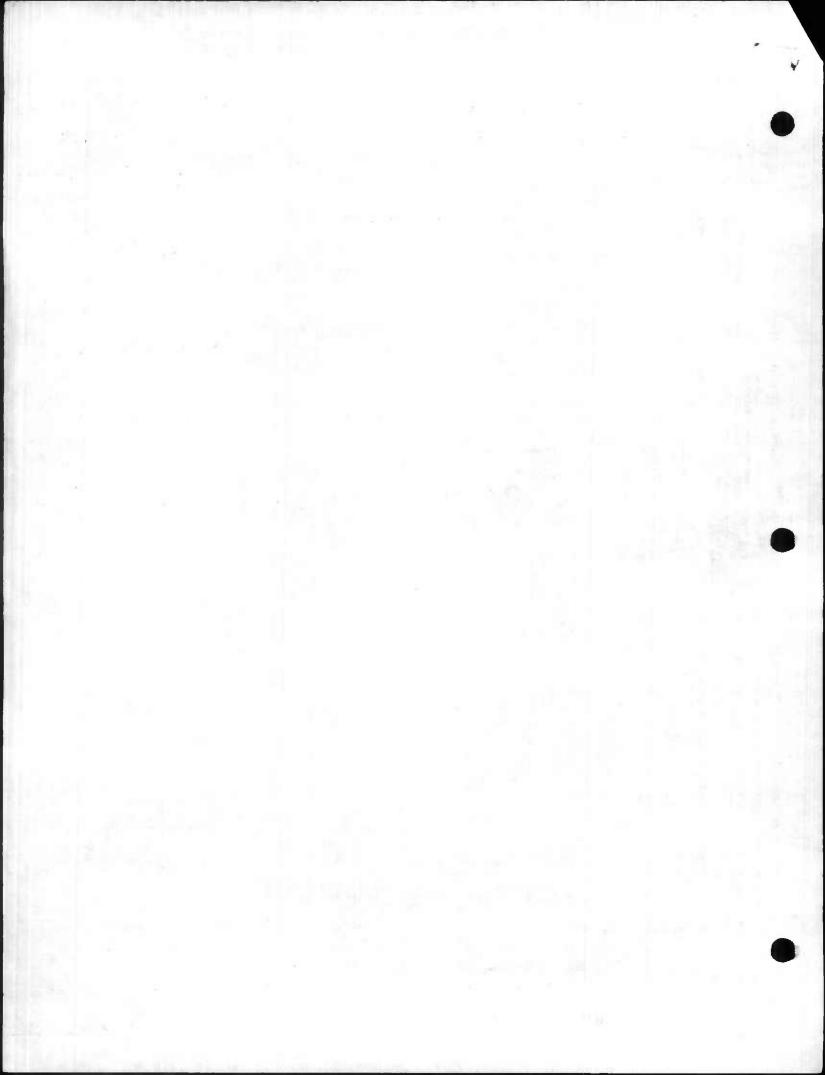
State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Eunice Agnes Adamson 24, 1999 February 4:45 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Manor Care-Potomac Potomac Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1□ M 21XF Months Deys Hours Yrs Director 577-07-0608 91 August 13, 1907 Georgia Usuel Rasidenca of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location na 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours effer death 1 Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, tra Medical Examiner manages. 6304 Lone Oak Drive 20817 United States Funeral 12. Was Decadent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 by 3 Widowed 4 □ Divorcad Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) 12 Telecommunications Operator Baltimore, Maryland 17. Fether's Nema (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Surneme) Be William Edgar Cole Anne Crotty 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20854 19e. Informent's Name/Reletionship (Type, Print) Ronald C. Johnson/Son 9017 Wandering Trail Drive, Potomac, Maryland 20b. Plece of Disposition (Name of cometery, cremetory or other place) February 27, 1999 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Rockville, Maryland Parklawn Memorial Park Signeture of Funerel Service Licensee ... 22. Neme end Address of Fecility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M00846 23a. Pert1 Enter the disease, or complicetions shock, or heart feilure. List only one city is that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, see on each line. Approximate Interval Batween Onset and Death Physician Immediete Ceuse (Final disease or condition rasulting in deeth) /Medical MYOCACIAL INFALTION Examiner Examiner or Attending Physician: The lew requires that the death certificate be executed buriel-transit and Sequantially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated evants resulting in deeth) Lest Due to (or as e consequence of): Box 68760, ettending physiclan Physician/Medicai the Due to (or es e consequence of) signed by the et Id be deteched fo Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? I WNT DISEASE 1 Yes 2 No 3 Probably 4 Miknown Completed by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? (TROKE, ATRIAL FIBRUMUS 26. Wes en eutopsy performed? HEALT FAILURE CONBESTIVE 2010 1 ☐ Yes 1 Tyes 2 No. 25. Wes case rafarred to medical exeminer? Be 26. Piece of Beeth (Check only one) Hospital: Certification: To 1 Yas 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Data of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding Investigation 1 Natural To the Hospital or Attendin within 24 hours efter deeth.
To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicide 28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledga, deeth occurred et the time, date end placa, end due to the causa(s) end menner as steted. Medical 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted. 29b. Signature and title of certifig 29d. Dete signed (Month, Dey, Year) 30. Neme end eddress of person who edmplated cause of deeth (Item 23e) (Type, Print) Elliot R. Goldstein, M.D., 9410 Old Georgetown Road, Bethesda, Maryland 20814-1700 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State MAR 02 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Certificate o	f Death		Reg. No.9	0.8	1396		
	6	1. Decedent's Neme (First, Middle, L.	nst)				2. Dete of Dea Month	ath	Vanz	3. Time of Death		
	Physician /Medical	MARGARE	T ANDERSON				Feb.	28 19	999	6:50 A.M.		
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	Funeral Director	578 26 1810	Sex 7. Age (In)	rs. last birti 81 Y	Mantha Day			y. Year) 0,1917	9. Birthpl Count Phila	lace (Stete or Foreign try) adelphia, PA		
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a Marvia	a or 28a-f show be notified at Director	Maryland Prince			tsville					1 X Yes 2 No		
Maryland 21215-0020 d 2 should be filed within 72 hours after death with it th and Merial Hydens.	23a or 2 unt be no	10e. Street and Number 4922 LaSalle Ro	i.		10f. Zip Code 207			10g. Citizen of V				
	Examiner in by Funer	11. Marital Status 1 Never Married 2 Merried 3 N Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	n U,S.	13. Was Decedent of If Yes, specify Control of It Yes 2 № h		Specify Yes or No- to Rican, etc.)	pecify Yes or No- o Rican, etc.) 14. Race- Black, Specify:		American Indien, White, etc. Black		
5-0	fical dical	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Occ	supation	nrkina	16b. Kind of Bu	usiness/Ind	lustry		
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altimore	nent of H ant: If the ary or oth	20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removel from State	cemetery	Disposition (Name of c, cremetory or other p ny Memoria		Date 6/99	20c. Location -		wn, Stete Iaryland		
Balt	Departri Importa any Inju	21. Signature Funeral Service Utensee 22. Name and Address of Facility MCGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Washington, D.C. 2										
1	nysician Medical xaminer	Immediate Cause (Final disease or congression of heart failure. List only limited to the congression of the cause (Final disease or candido resulting in death)	Chronic Due to	Rena (or es e c	1 Failure onsequence of):	ying, such es carola	c or respiretory er	1651,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximete Interval Between Onset end Death		
pet	min min		b	Hypertension Due to (or es e consequence of):								
68760,	physician and is the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	C									
	5	resulting in death) Last Due to (or es e consequence of):										
	of for	Part II. Other significant conditions	contributing to death but not	resulting in	the underlying cause	given in Part I.	23b. Did 1	lobacco use co	ntribute to	the cause of death?		
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Records, P.O. Box	hould be						24a. Wes perfo	an autopsy med?	eva	ere autopsy findings allable prior to appletion of cause deeth?		
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	ortor, j	25. Wes case referred to medical				26. Place of De	eeth (Check only one)					
of Vital		examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient 2	□ ER/Out	patient 3 DOA	Other: 4 Nursing I	Home 5 Resid	dence 6 Oth	er (Specify	1)		
Division or Attending		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Ti	jury V	jury at /ork?	28d. Describe I	now injury occur	red			
	ns after death. el Director: After t led in by the funera Certification:	3 Suicide 6 Could not to determined		t home, fer	m, street, factory, offic	28	28f. Location (S City or Tox		er or Rure	l Route Number,		
I Hospital	n 24 hours he Funeral pletaly filled edical C		nysician: To the best of my lender: On the basis of exame and manner steted.									
Tot	To the comple	29b. Signature and title of certifier Merc Sawa	12/6	Zuc		14290		29d. Date signe March 4				
		30. Name end address of person who Meer Said Zonoz			Type, Print) thern Ave.	S.E. #30	7 Washi	ngton.	D.C.	20032		
	State Registrar	31. Date filed (Month, Day, Year) MAD 0 5 199	32. Registrar's Si	onature	Soon					20002		



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 2, 1999 7:45 AM Reuben **Alleyne** Kenneth /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park 6701 Allegheny Avenue Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplaca (Stete or Foreign **Funeral** Deys Months Hours 74 Yrs Director 579-74-8655 Jan. 13, 1925 Trinidad & Tobago Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits rel', or itema 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Montgomery Maryland Takoma Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6701 Allegheny Avenue 20912 Trinidad & Tobago death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11 Merital Status 12. Was Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or item eny injury or other treumatic event, the Medical Examinat Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Auto Body Technician Car Dealership 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Be Rebecca Hubson Reuben Alleyne 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6701 Allegheny Avenue, Takoma Park, MD 20912 Enid L. Alleyne (wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ØCremetion 3 ☐ Removal from State 3-6-99 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Liga 22. Name and Address of Facility
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 M00956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiorespiratory Arrest Examiner Due to (or as a consequence of): Examiner Carcinoma of the Floor of Mouth sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical Due to (or as a consequence of): 93 980 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 X Yas 2 No 3 Probably 4 Unknown been signed t should be det Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 2X No 1 ☐ Yes 2 No certificate 1 ☐ Yes or Attending Physician: funeral director, Be 25. Was case referred to medice! 26. Placa of Death (Check only one) Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 2 1 Tes 2 TaNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 ("XNatural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier March 3, 1999 P 30. Name and address of person who completed death (Nem 23a) (Type, Print)

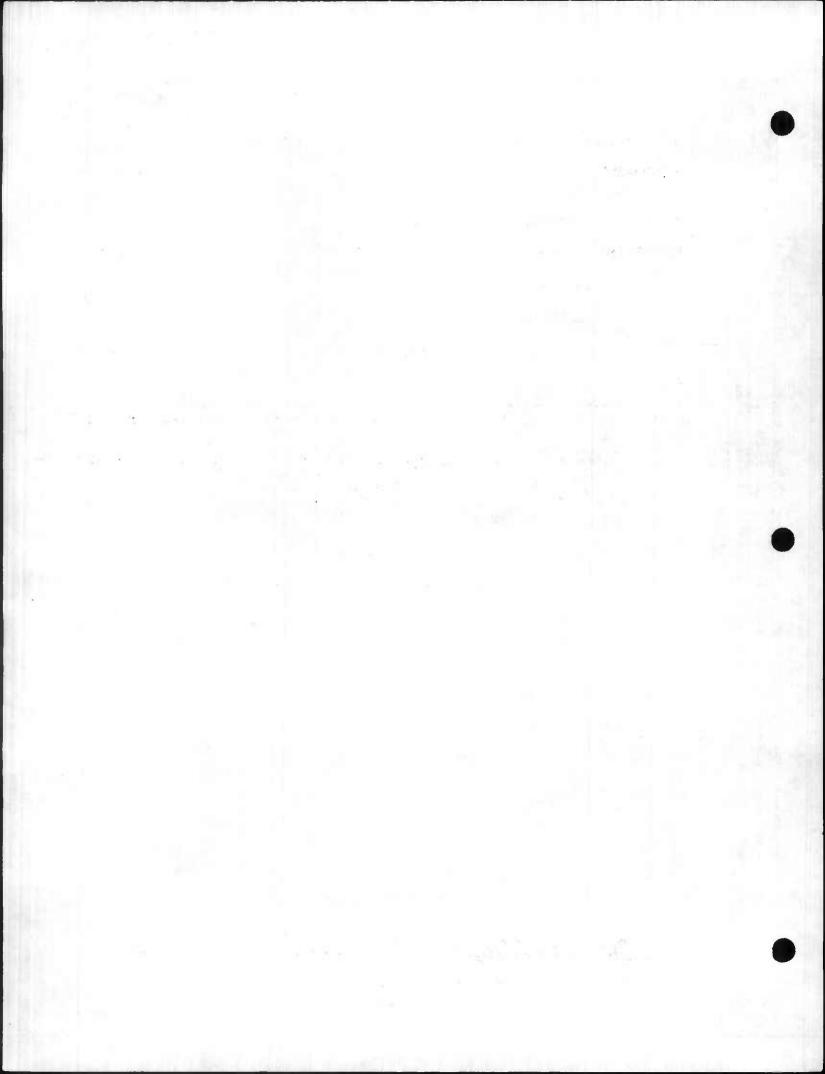
Ernest Meyers, M.D., 2041 Georgia Avenue, NW, #4B27, Washington, DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

MAR 04 1999

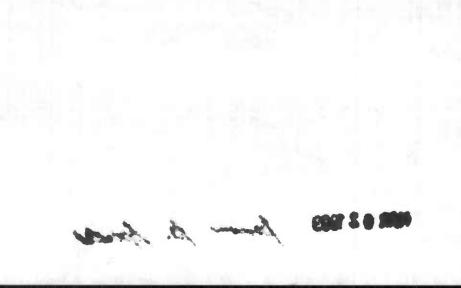
32. Registrar's Signature

Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 08 9

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	/Medical Examiner	4a Facility Name (give straet and n	umber)						ocation of Dea	th 4c. Cou	nty of Death	
-	Funeral	5. Social Security I	Number (3. Sax 1 □ M 2 ☑ F	7. Aga (In	yrs. last birthday)	If Und Months	ar 1 Year S Days			8. Date of B (Month, D	irth Day, Year)	9. Birth Cor	nplace (State or Foreign untry)
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To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the f

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Certifica

Medical

29a. Certifiar (Check only one)

March 2, 1999

Wawa Store

Harford County, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end mennar as stated.

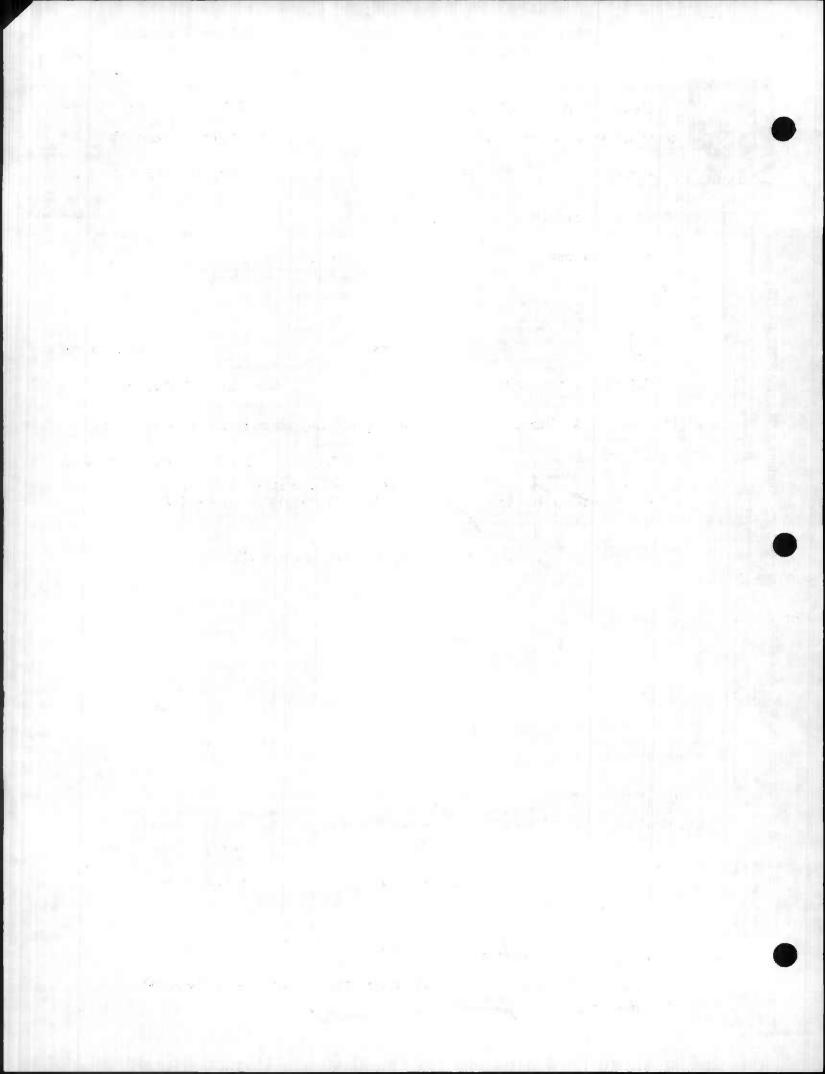
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. 29d. Date signed (Month, Day, Year) 29c. License number

O.C.M.E.

30. Nama and address of person who completed cause of deeth (I)em 23a) (Type, Print)

Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar



						Cer	tificate	of I	Death			Reg.	No.	U	0400
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4a Facility Nama (If no	ot Institution,	giva st	reet and nu	ımber)				4	b. City, To	wn, or Lo	ocation of De	ath	4c. County	of Deat	h
Northhampt			Nurs					11111	rede				Frede		
5. Social Security Numb		6. Sax	M 2X F	7. Aga (i		st birthday) Yrs.	If Under 1 Months	Days	If Undar Hours	Min.	8. Data of I (Month, I Mar.	Birth Dey, Ye	ear)	9. Birt	hplaca (Stata or Fore
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Frederick, MD 21701

700 Montclaire Ave. 32. Registra's Signatura

State Registrar

Robert Hughes, MD, 31. Data filed (Month, Day, Year)

AR 0 8 1999

Physician /Medical Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprint Fruit by notified anone.

Physician /Medical Examiner

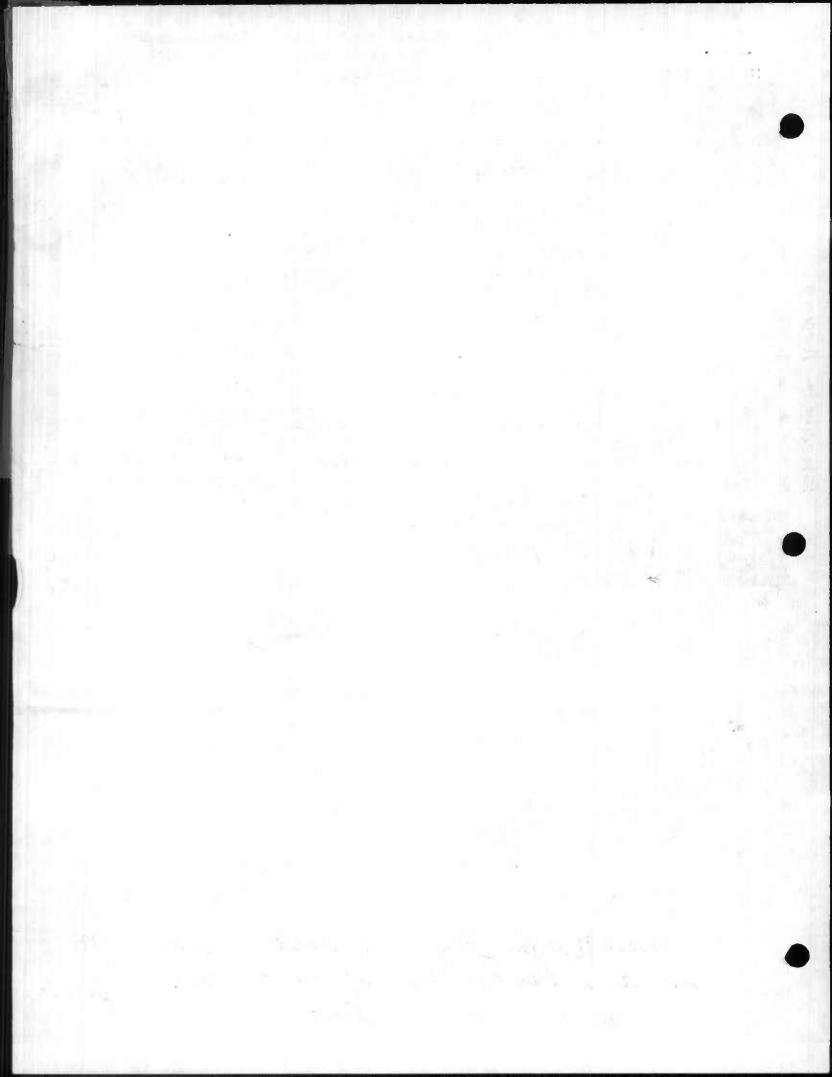
within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funerel director, page 2 should be deteched for use as the buriel-transit To the Hospital or Attending Physicien: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ITEMS: #5	R F.H. G769 3-31-99 WR	State of Maryland	Certifica				giene Reg. No. 9	081	10:
Physician /Medical	Decedent's Name (First, Middle, Last) ELIZABI		ADAMS			2. Date of Dea	Day 1	1999 0	530
Examiner	Fecility Name (If not institution, give st. Dorchester Gene			46	Cambr	or Location of Death idge		of Death chester	
Funeral Director	214-30-7734	7. Age (In yrs. le	est birthday) If Und Yrs. Months		If Under 24 H Hours M		r, Year)	9. Birthplace (5 Country) Marylar	
show ed.at	ual Residence of Decedent a. State 10b. County MD Dorches:		, Town or Location Cambride	ne ne					ide City Limit
be notified at	e. Street and Number			tip Code 216	12		10g. Citizen of 1		Yes 273W
or items 23e or uniner must be remained by Funeral Di	4845 Buckton Marital Status 12 Never Married 22 Married	Was Decedent Ever in U,S Armed Forces 1 ☐ Yes 2 ☐ No	S. 13. Was Dec	edent of His	panic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Rac	e - American Ind ck, White, etc.	ien,
D Ex	3 Widowed 4 Divorced 15. Decedent's Educe	If Yes, Give' Year or Dates:	1 ☐ Yes		Specify:		Specify	whi	te
nt, the Medical	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give kind of w life. DO NOT	vork done du	ring most of w	vorking		te duty	
Be	Father's Name (First, Middle, Last) John	W. Tieo	ler	1		ame (First, Middle,	Maiden Sumen	Tubman	
5 5	a. Informant's Name/Relationship (Type Roger F. Adams – h		19b. Mailing Addres			Rural Route Numbe			
ry or other t	a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	20b. Ple	ece of Disposition (Nametery, crematory or Lisbury Cre	ame of other place))	Date 3-1999	20c. Location -	City or Town, Sto	
any injury or ones.	Signature of Funeral Service Licensee	1. 9.	22. Name a	and Address	of Fecility T	Thomas Fur ambridge 1	neral Ho	ome PA	
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cate has been signed pege 2 should be de Completed by F						24e. Was a perfor		24b. Were auto avsilsble completio of death?	opsy findings prior to n of cause
nis certificate Il director, peg To Be Co	Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hos	pital: 1 ☑ Inpatient 2 ☐ E	R/Outpefient 3 □ D	Other		eath (Check only or Home 5 ☐ Resid			
After thi funeral	2 Accident investigation			28c. Injury a Work?		28d. Describe h			
To the Funeral Director: completely filled in by the Medical Certifical	4 Homicide determined	 Place of Injury - At horr building, etc. (Specify) 	ne, farm, street, facto	ry, office		28f. Location (S City or Tow		er or Rurel Route	Number,
To the Funeral D completely filled i	(Check only one) 2 Medical Examiner	 an: To the best of my knowl On the basis of examination and manner stated. 	on and/or investigation	n, in my opin	lon, death occ	curred at the time, o	ate and place,	and due to the ca	
000	Signature and title of certifier	they to	29	C. License n	1609	ST. CA	9d. Date signed MARCH	(Month, Day, Ye	19 19
	Name and address of person who come	oleted cause of death (Item 2	23a) (Type, Print)	103	BYRD	ST. CA	MBRID	GE M	0:3
State Registrar	Date filed (Month, Day, Year)	32. Registrar's Signatu	re 4	loan	V. 1			21	612



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MEL BA WINIFRED CANTER-BEECHER MARCH 1, 1999 8:40 A.M. 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Lusby Calvert 11565 Senora Lane If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) an. 9,1924 5. Social Security Number if Under 1 Year Birthplece (State or Foreign Country) 7. Age (In vrs. lest birthday) 10 M 20 F Months Days West Virginia Yrs. 578-34-1764 75 Usual Residence of Deceden 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Hughesville Maryland Charles 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 20637 15450 Scout Camp Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Harry L. Riggs Maude Tenney 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lennard G. Beecher/Husband 15450 Scout Camp Road, Hughesville, Maryland20637 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 03-05-1999 Clinton, Maryland 4 Donation 5 Other (Specify) Resurraction Cemetery 22. Name and Address of Facility The Huntt Funeral Home, Inc. 21. Signature of Funeral Service Licenses MO1098 P.O. Box 156, Waldorf, Maryland DAVID A. GOFF 23a. Part1. Enter the disease, or complications that cauthur he death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each limit. Approximete Interval Between Onset end Deeth CARCENOMA OF LUNG Immediate Ceuse (Finel FEW WEEKS disease or condition resulting in death) Due to (or es e consequence of) Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were eutopsy findings available prior to completion of ceuse of deeth? CONGESTIVE HEART FAILURE 24a. Was en eutopsy

Physician /Medical Examiner

physicien and the buriel-transit

signed by the e

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funeral

of attending Physician: Tells of the objector: After this certification

To the Hospital or Attel within 24 hours efter des To the Funeral Director completely filled in by the

that the death certificate be executed

Division of Vital Records,

Examiner

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r than "natural", or leams 23s or 28s-f show the Medical Examiner must be notified at

8

72 hours after death

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Hygiene.

is marked other

permit. Pages 1 and 2 st Department of Health and Important: If New 27 is m

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Physician/Medical

1 Yes 2 No 1 Yes 2 No

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pending

28e. Date of Injury (Month, Dey Year)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 28b. Time of

26. Place of Deeth (Check only one)

1 Yes 2 No

Other: 4 Nursing Home Residence 6 Other (Specify) 28d. Describe how injury occurred

2 Accident 3 ☐ Suicide 4 Homicide

Investigation 6 Could not be

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier

29c. License number 126064 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po

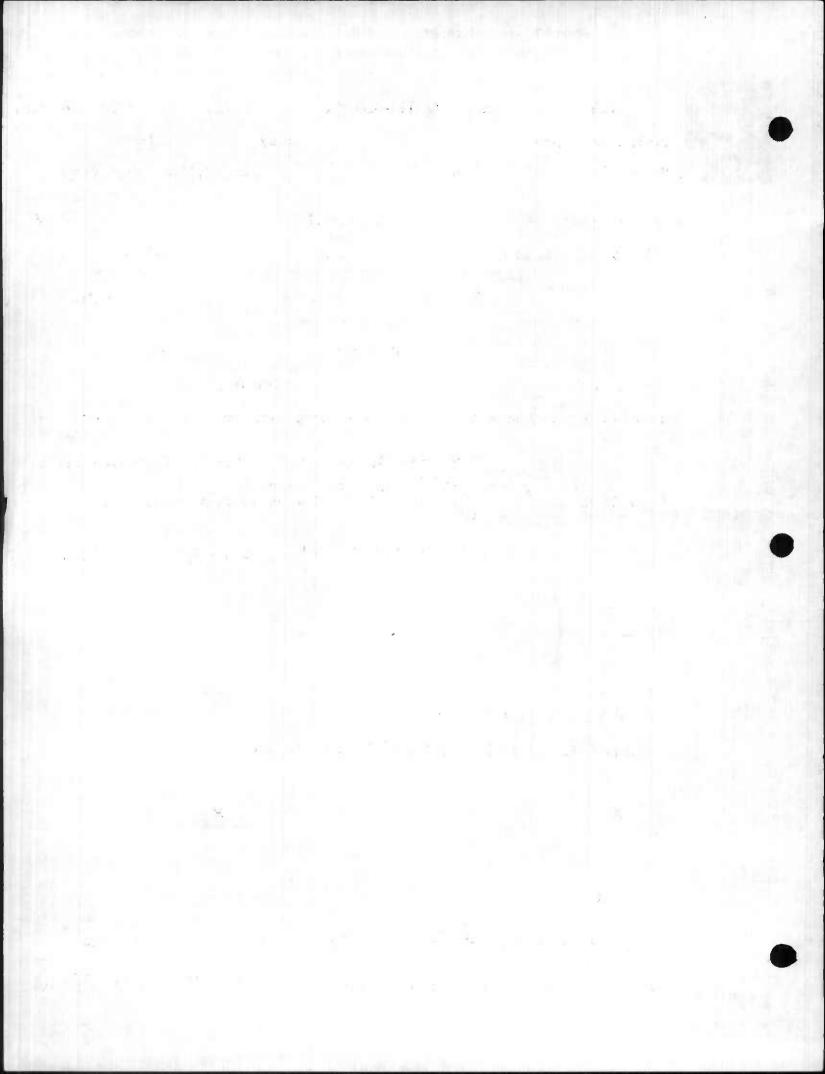
31. Dete filed (Month, Day, Year)

MAR 0 5 1999

Box 32. Register's Signature Comer

Charlotte Hall, Md 20622 989

State Registrar

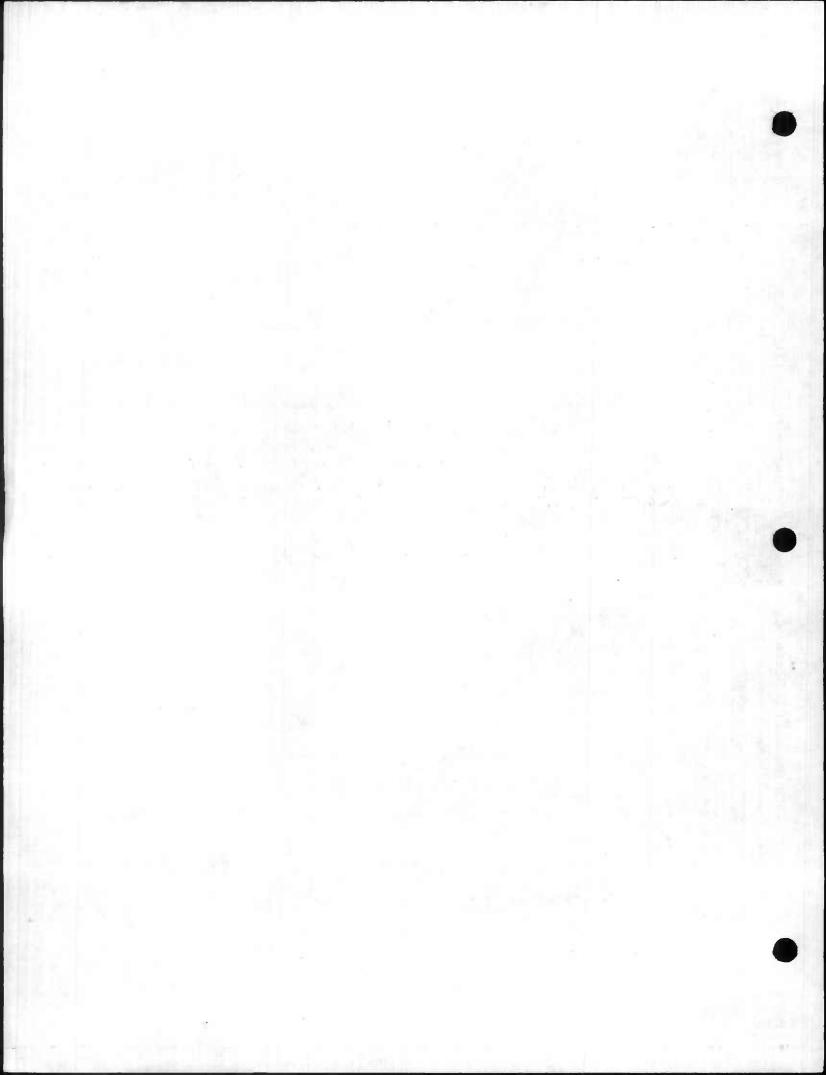


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State of Maryland / Department of Health and Mental Hygiene

			Ce	ertificate of	Death	Re	g. No.	08403
	1. Decedent's Name (First, Middle, La	st)				2. Date of Deeth	1	3. Time of Death
Physician (Madiae)	Harold R. Bake	r				Month MARCH	Day / 40	Year 1: 40 An
/Medical Examiner	4e Facility Neme (If not institution, give				4b. City, Town, or		4c. County of	
	Washington Adven	tist Hospital			Takoma 1	Park	Mont	gomery
Funeral	5. Social Security Number 6. S	Sex 7. Age (In yrs	. last birthday				Veed	Birthplece (State or Foreign Country)
Director	579-10-3747 Usuet Residence of Decedent	20 M 2□F 80	Yrs.	Months Days	Hours Min.	February 4		Pennsylvania
aryland show dati	10a. State 10b. County	10c. C	City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 No
or 28e-f. be notified	Maryland Montgom	ery	Silver	Spring		1.0		
	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nst Country?
ath nutt	513 Dennis Aven			2090				States
her death v r hams 23 siner must	11. Marital Stetus	12. Was Decedent Ever in Armed Forces?	U,S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Ongin? (S ean, Mexican, Puerl	o Rican, etc.)		- American Indian, , White, etc.
ors a		1 M Yes 2 □ No If Yes, Give Worl Year or Dates: War	dπ	1 ☐ Yes 2 🏋 No	Specify:		Specify:	White
ted feel	15. Decedent's Ed	ducation	16a Dec	edent's Usual Occu	pation	tina 1	6b. Kind of Bus	iness/Industry
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10 m 10 m 10 m 10 m 10 m 10 m 10 m 10 m	20e. Method of Disposition 1 Burial 2 Cremation 3	Removel from Stete	cemetery, cn	position (Name of emetory or other ple	(ce) March 3	, 1999	uc. Location • C	City or Town, State
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Depart Depart Import any in	21. Signature of Funeral Service Lice	Mullan Lawren	R	22. Name and Address Obert A. Pur 557 Wiscons:	mphrey Fune	ral Home/Be	thesda-C	hevy Chase, Inc.
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Dhusisian	23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.						Interval Between Onset end Deeth
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Examiner	disease or condition resulting in death)	a	WVG	47	NCAR		1	o or early
		Due to	(or as a conse	equence of):				
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death certificate be executed e attending physician and of for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to	(or es a conse	equence of):				
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ist the death certified by the attending letached for use a Physician/M								1
ysie d	Pert II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying cause gi	ven in Pert I.	23b. Did to	sacco use cont	ribute to the cause of death
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signe S be of								Oth Mars subsequifications
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The law eta has page 2						1 ☐ Ye	s 200 No	1 ☐ Yes 2 No
certificata rector, pag	25. Was case referred to medical				26. Place of De	ath (Check only one)	
	examiner?	Hospitel: 12 Inpatient 2	☐ ER/Outpation	ent 3 DOA Ot	her: 4 Nursing h	lome 5 ☐ Resider	nce 6 Other	r (Specify)
F Fig	27. Manner of Death	26a. Dete of Injury (Month, Day Year)	28b. Time	of 28c. Inju		28d. Describe hor		
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tal or Attending P rs after death. al Director: After t ied in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not b	286. Piece of injury - At	home, ferm, s	street, factory, office				r or Rural Route Number,
d in dir	4 Homicide	building, etc. (Spec	erry)			City or Town,	Stete)	
aplta neral fille	29a. Certifier Certifying Ph	ysician: To the best of my kn	owledge, dee	th occurred et the ti	me, date and place	e, end due to the ca	use(s) end men	ner as stated.
To the Hospital or Attending within 24 hours after death, to the Funeria Bifer death, completely filled in by the fune weekling of the funerial management of the funerial management of the funerial confiderial certification	(Check only 2 Medical Exam	niner: On the basis of examinand menner stated.	ation and/or i	nvestigation, in my	opinion, deeth occu	irred et the time, de	te and place, er	nd due to the ceuse(s)
Vithin Vithin Comp	29b. Signeture and title of certifier	n, O		29c. Licen	se number	29	d. Date signed	(Month, Day, Year)
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(12)	30. Name and address of person who	Completed cause of death (Its	тт 23a) (Туре	GRAX	SNBEXT	HNOVER	20770	WAY
State	31. Dete filed (Month, Day, Year)	32. Registrar's Sign	nature	-				
Registrar	MAR 0 5 19	99 Beneva	19.	Spark	11			

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State of Maryland / Department of Health and Mental Hygiene 9 0 8 4 0 4

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Funeral		5. Sociel Security Number	S. Sex 7. A	lga (In yrs. la	st birthdey)	If Under				Data of Birth	h	9. Birthpleca	(Stata or Foraign
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within 24 hours after death To the Funeral Director: completely filled in by tha	edicai	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and menner s	of axaminatio	edge, deeth on end/or inv	occurred e astigation,	t the tir	me, dete end opinion, death	plece, end occurred	due to the o	euse(s) end mo date end place,	enner es stete end due to the	d. ceuse(s)
To the within 2 To the comple	Σ	29b. Signature end title of cartifier				29c.	Licens	se number		2	29d. Date signe	d (Month, Dey	Year)

12

State Registrar 809 Viess Mill Rd Rockerille, Ma 20851

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

D33443

Mas 1, 1999

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State

Registrar

31. Data filed (Month, Dey, Yeer) MAR 0 5 1999

29b. Signature end titla of cutiling

John R. Melnick, M.D. 911 Russell Avenue, Gaithersburg, Maryland 20879 32. Registrer's Signetura

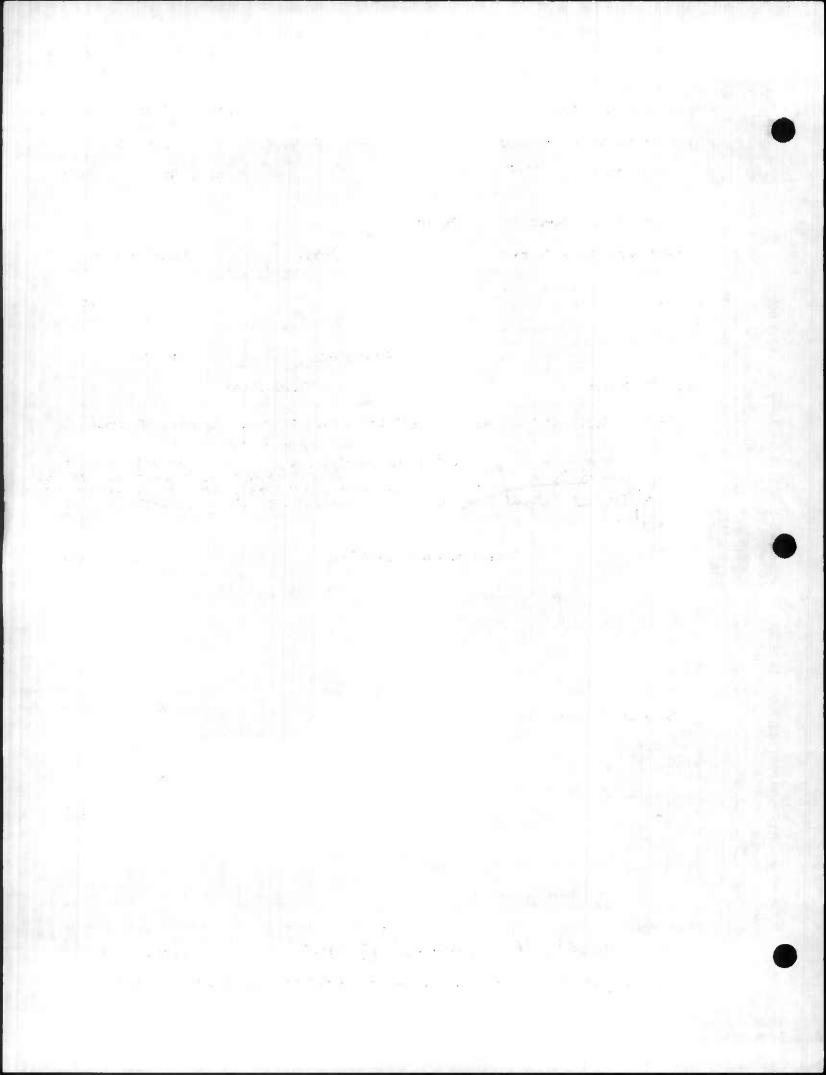
30. Neme end eddrass person who completed causa of deeth (Item 23e) (Type, Print)

29c. Licansa number

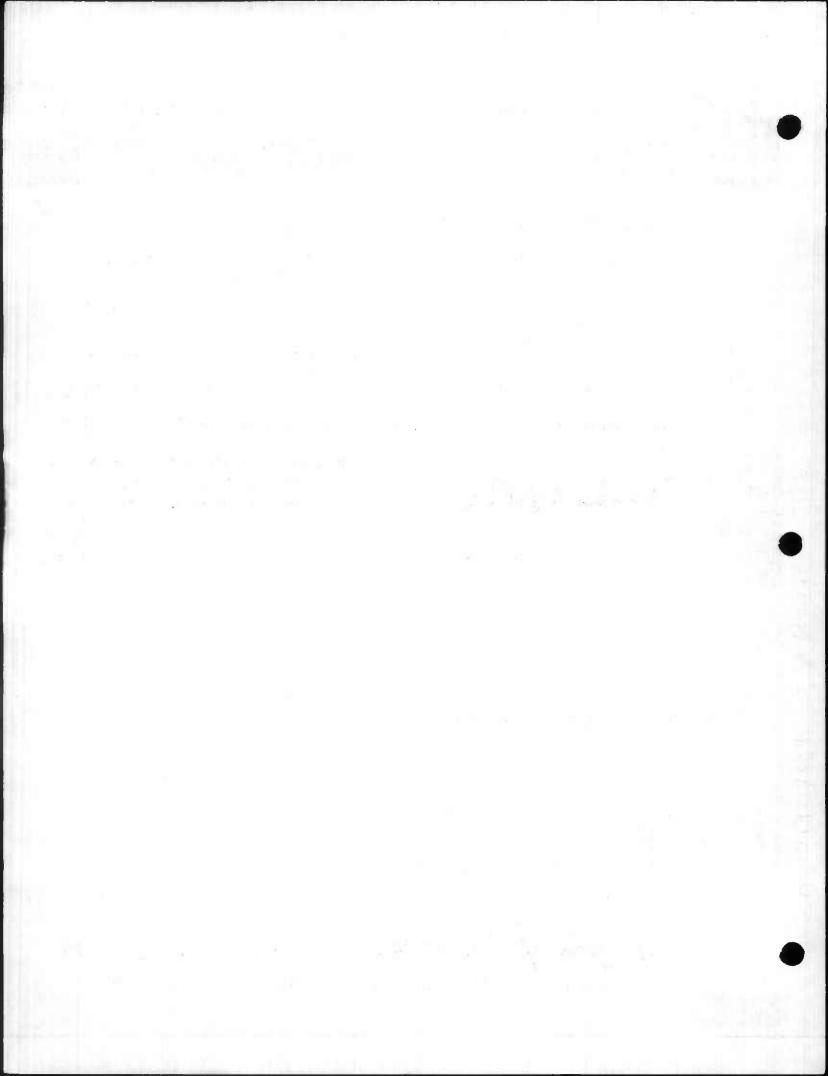
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29d. Date signed (Month, Dey, Year)

March 4, 1999

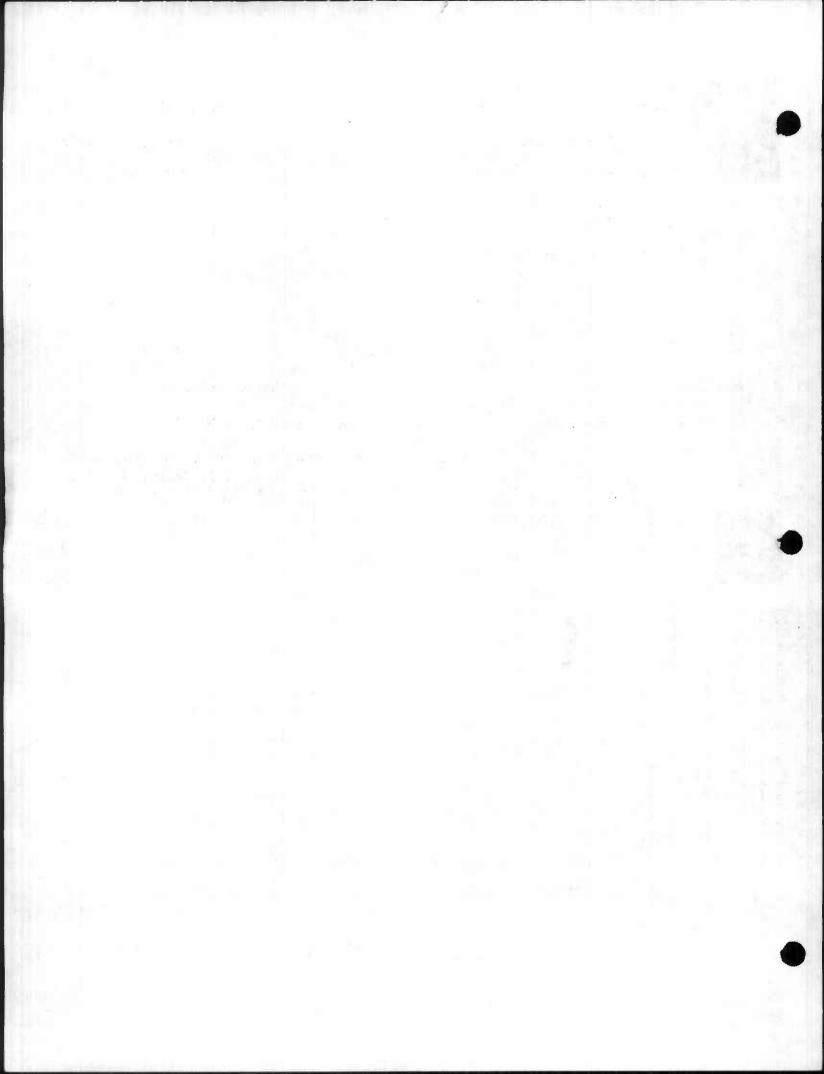


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unerai		5. Social Security Number	6. 9		7. Age (In)	rs. last birthday	If Under		If Under	24 Hrs.	8. Date of Bir	th	9. Birthp	lace (Stata	or Foreign
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Ι.		19a. Informant's Name/Ra	lationship (Type, Print)		19b. Maii	ing Address	(Straat	an <i>d Numba</i>	r or Rura	l Route Numb	er, City or Town,	Stata, Zip	Code)	٠
F		Anne M. Becl	./Wife	2		11512	Hitc	hing	Post	Lar	e, Roc	kville,	MD.	20852	
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O Be	ונ	examiner? 1☑ Yes 2☐ No		Hospital:	tonations f	7 FD/0-1	-4 n - 0	Othe	or				- (0 2		
	- -	27. Manner of Deeth		28e. Date		28b. Time of		JA	4 LI NU			denca 6 □Oth		v)	
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		Joseph D. Co 31. Date filed (Month, Day,					e PTA	α.,	11 300	, KC	CKATTT	e, MD.	10072	-	
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		,		nai yia		tificate of	Death		Reg. No.	0	8407
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Examiner		4a. Facility Name (If not institution,		r)			4b. City, Town, or	Location of Daeth			
Funerai Director		Magnolia Nursing 5. Social Sacurity Number 261-43-4844		Age (In yrs	. last birthday) Yrs.	If Undar 1 Yaar Months Deys			th y, Yaer)	9. Birthp	orge's laca (Steta or Foraig ington, Do
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any injury or other traumatic event, the medical and once. To Be Completed by	-	20a. Mathod of Disposition	CKIIIdiiii	20b.	Place of Dispos	sitlon (Nema of		Deta Deta	20c. Location	- City or To	wn, Stete
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		Padmaya	S. Uda	pi	MDOA	D24	174		3 3 1	999	
	3	10. Nama and addrass of person who Padmaja S.	Uclub I	daath (Iter	n 23a) (Type, P	Print)					
State egistrar	3	11. Deta filed (Month, Dey, Year)	32. Regist	rar's Signa	atura 4	Soon	1.1				



Piease Type or Print in Biack indelible ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year SHETT DA ELIZABETH BELL MARCH 1999 5:30 am 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death MAGNOLIA CENTER If Under 24 Hrs. 8. [Hours Min. PRINCE GEORGES 8. Dete of Birth (Month, Dey, Year) If Under 1 Year Birthplace (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Days Months 1□M 250 F Yrs. 49 11, 577-68-7248 DC 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 117 Yes 2 □ No Prince Georges Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 608 Cedarleaf Avenue 20743 United States 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 22€ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: Black. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Off Set Printer Federal Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Darby Bertha Jones 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2013 Belfast St., Ft. Washington, MD 20744 e of Disposition (Neme of Dete 20c. Location - City or Town, State Lawrence H. Bell, Sr. (Husband) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a, Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 3/6/99 Harmony Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) Landover, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Fecility R. N. Horton co. Morticians, Inc. Huton 600 Kennedy Street, N. W., Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARCINOMA OF PAROTID Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 TVes 2 No 26. Place of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

ms 23s or 28s-f show

than "naturel", or items

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 Ie marked other than "naturel", or item eny Injury or other traumatic event, the Medical Exercises pages.

Baltimore, Maryland 21215-0020

Director

Funeral

2

Completed

Be

MD

death with the Maryland

Examiner Physician/Medical à Completed Be 2

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

physician and s the burial-transit 88 950 signed by the a peen page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Certification:

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Natural 2 Accident 3 Suicide

6 Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

4 Homicide

(Check only one)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

edical

SINGH 31. Date filed (Month, Day, Year)

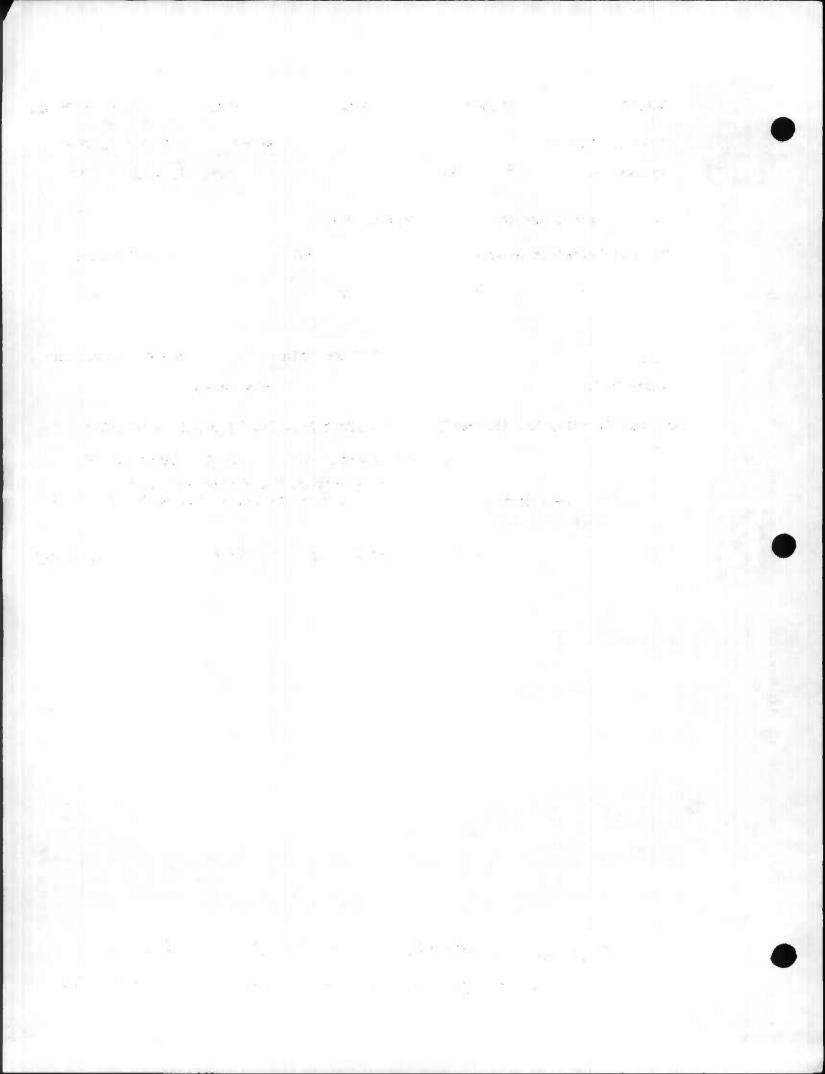
1209A NANOVER 32. Registrar's Signature

PARKNAY. GREENBEUT, MD 20118

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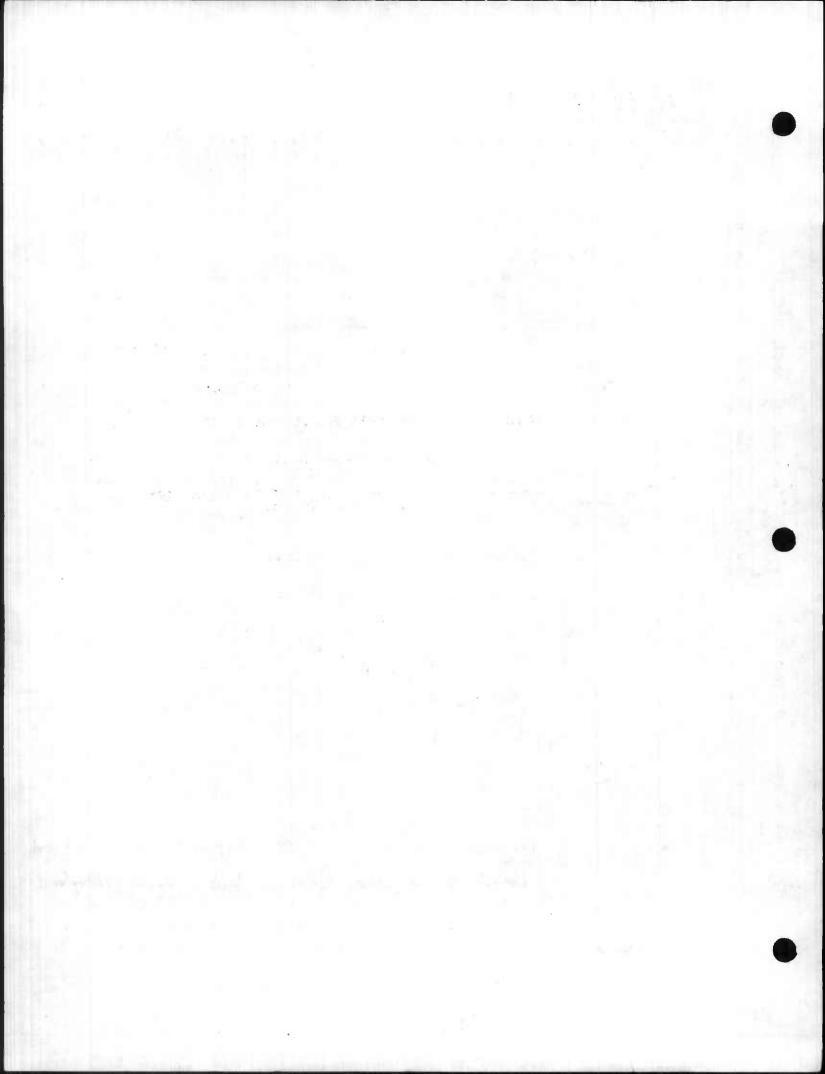
Registrar

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				Certific	ate of	Death			Reg. No.	U	3409
Di	1. Decedent's Name (First, Mic	Idle, Last)						2. Date of De Month	Day	Year	3. Time of Death
Physician /Medical	RUTh	3 erday						Feb.	23 /	999	9:06.Pm
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Funeral Director	5. Sociel Security Number 579–24–9352		85	Yrs. Mont			Min.	(Month, De MARCH	y, Year) 5, 1913	VAS:	lace (State or Foreign try) H. DC
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	10e. Street and Number	CK AVENUE		10f.	Zip Code 2091()			10g. Citizen of V USA		try?
D20 Dy F	11. Meritel Stetus 1 Never Married 2 M 3 Widowed 4 Divorce	If Yes. Give	?] No			Hispanic Or pan, Mexica Specify		ecify Yes or No Rican, etc.)		e - Americ k, White, o	etc.
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121 Man Man	Elementery/Secondary (0-12		5+)	life. DO NO	T use retire	ed)			OWN	HOME	
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Division of the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		al Examiner: On the basis and mennar s	of examination a								
o the complete of the complete	29b. Signeture and title of certi	fier			29c. Licen	se number			29d. Date signe	d (Month,	Day, Year)
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	30. Name and address of person Phillip W. Poth,	on who complated causa of			lue-	5-1	100.00				
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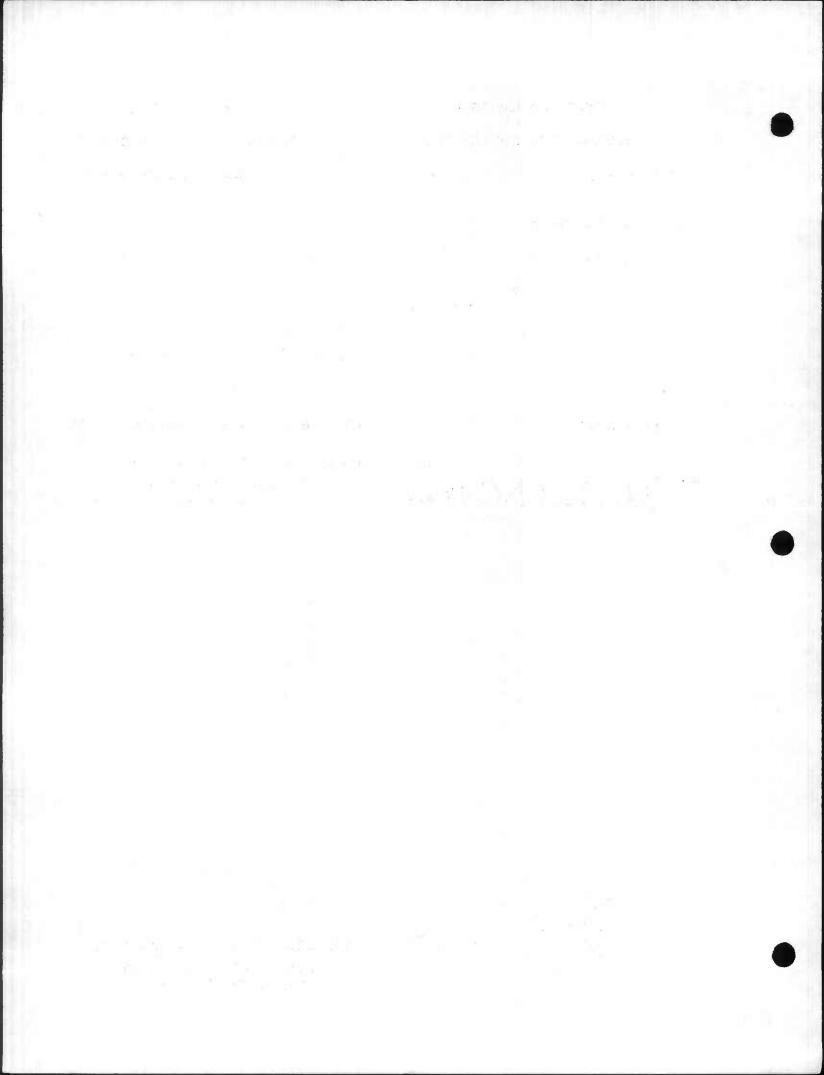


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State of Maryland / Department of Health and Mental Hygiene 9 08 1

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	Exami		4a. Facility Nama (If not institution, giv	a street and number)				4b. City, Town, or I	ocation of Deeth	4c. County	of Death	
			NATIONAL NAV	AL MEDICA	L CENTI	ER		BETHE	SDA	MO	NTGOME	RY
	Funeral Director		5. Sociel Security Number 6. S 081-16-9075 Usual Residence of Decedent	Sax 7. As	ge (In yrs. lest 77		Under 1 Yaar Inths Deys	If Under 24 Hrs. Hours Min.	6. Data of Birth (Month, Dey, Jan. 27	Yeer) , 1922	9. Birthpleca Country) New Yo	(Stete or Foreign
	how		10e. Stete 10b. County		10c. City, To	own or Locatio	n					Inside City Limits
	Ma uther	Ş	Maryland Montgom	ery	Der	wood					1	I ☐ Yes 2₺ No
	th th	Director	10e. Street end Number			10	of. Zip Code		16	0g. Citizan of V	Whef Country?	
	h wi	aic	7117 Blanchard Di	ive.			208	355	1	United	States	
	dea F	Funeral	11. Marifel Stafus	12. Was Decedant Armed Forcas?		13. Wes		Hispanic Origin? (S en, Maxican, Puert		14. Rec	e - American Ir	ndien,
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, I'm Medical Examiner must be noutised at	by Fu	1 ☐ Nevar Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give Year or Detes:	No	10)	as 2⊠ No		o Mican, etc.)	Specify	ok, Whita, afc. v: Whi	to
Ö	2 ho		15. Decedent's Ed	ducation		Se. Decedent's	Usuei Occu	paflon		16b. Kind of B	w II I usiness/industr	
215	n n	Completed	(Specify only highest gra		F)	(Give kInd life. DO N	of work dona IOT use retire	during most of wor	king			
2	The state	E	Elementery/Secondery (0-12)	College (1-4or	0+)	Chief	Petty	Officer		U.S. N	avv	
	offle offle	BeC	17. Fether's Neme (First, Middle, Last)					1	ne (First, Middle, A		-	
<u>a</u>	ld be ked ked ic ev	To B	Myron	Bova	9				Ethyl		Haves	
Maryland	should N and N		19e. Informent's Neme/Reletionship (9b. Melling Ad	Idress (Street	and Number or Ru	-	City or Town,		fe)
	of Health ar item 27 is other trau		JoAnn Bova/Wife		7	117 R1s	nchar	d Drive,	Derwood	Maryla	nd 208	5.5
re,	Health Health tem 27		20e. Method of Disposition		20b. Place	of Disposition	(Neme of				City or Town,	
altimore,			1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif			tery, cremetor	•		10/1000	A - 1 2		
	The state of	1	21 Signature of Funeral Service Licer		Arlin	igton N	ationa	1 Cem. 3	3/2/1999	Arling	ton, vi	rginia
0	permit. Page Department of Important: If any Injury or pance.		Mulm	QN Cm	lelia			er Park I				20877
			23e. Part1. Enter tha diseese, or com shock, or heert feilura. List only	plications that cause	the deeth. D	o not entar the	mode of dyi	ng, such es cardiac	or raspiretory arre	esf,	Apr	proximeta arval Between
	Physician /Medical Examiner		Immediate Ceuse (Fine) disaasa or condition resulting in death)		EUMONIA							sef and Deeth
		e	resulting in county		Due to (or es	e consequenc	e of):					
	cuted nd transit	Examiner	Sequentially list conditions,	b. —	Due to (or es	e consequenc	a of):					
60,	icate be executed physician and s the burial-transit	ai Ex	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events	C							į	
ox 68760,	5 0 0	Medical	resulting in death) Lest	d	Dua to (or es	a consequano	e of):					
Box	death cert e attendin e for use	clai										
P. O.	the the	Physiclan/	Part II. Other significant conditions o	onfributing to death b	uf not resulting	g in the underl	ying cause gi	ven in Pert I.			ntribute to the 3 ☐ Probabl	cause of death? y 4⊠ Unknown
Ś	8 50	by										
Record	been should	Completed							24a. Was er parform	n autopsy ned?	availeb	outopsy findings le prior to ofion of cause h?
æ	0 - 0	E O							√X ve	s 2 No	1 □ Ya	s 2 No
Vita	certificate		25. Wes case referred to medical					26 Place of Dec	ath (Check only on		1010	243110
>		o Be	examiner? 1 Yes 2 No	Hospitel:	ما ما	Outroffeet 2	DOA Ot	her			(016-1	
ō		: To	27. Menner of Deeth	1 □Xinpatio		Outpafient 3	28c. Inju		oma 5 Rasida 28d. Describe ho			
o	ding Phy th. After thi funeral	tio	1 Neturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, De	y Year)	Injury N		rk? Yes 2 □ No				
Division	of a strending after death. Director: After din by the fune	Certification:	3 Sulcida 6 Could not be determined	28e. Plece of Inj building, et	ury - At home, c. (Specify)	ferm, street, f	ectory, office		26f. Location (St. City or Town		per or Rural Ro	ute Number,
	To the Hospital or Attending within 24 hours after death. (* To the Funeral Director: After Tompletely filled in by the fun	edicai C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best niner On the basis o and manner st	exeminetion :	lge, deeth occi end/or invastig	urred at the ti	me, dete end plece	, end due to the ce rred et the time, de	ouse(s) end me ete end pieca,	enner es stetec and due to tha	i. cause(s)
	o this	Me	29b. Signature and title/of copings	/			29c. Licens	se number	25	9d. Data signe	d (Month, Dey,	Year)
1	371		× ////	1	M		0101-	050763 (1	VA)	2/23	199	
	V '	ŀ	30. Neme end affdress of person with	completed cause of d	eath (Item 23	e) (Type, Print)	NATIONAL	NAVAL ME	DICAL	CENTER	
			JOHN MCDYER, M					BETHESDA		1		
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registr	er's Signetura	6	/					

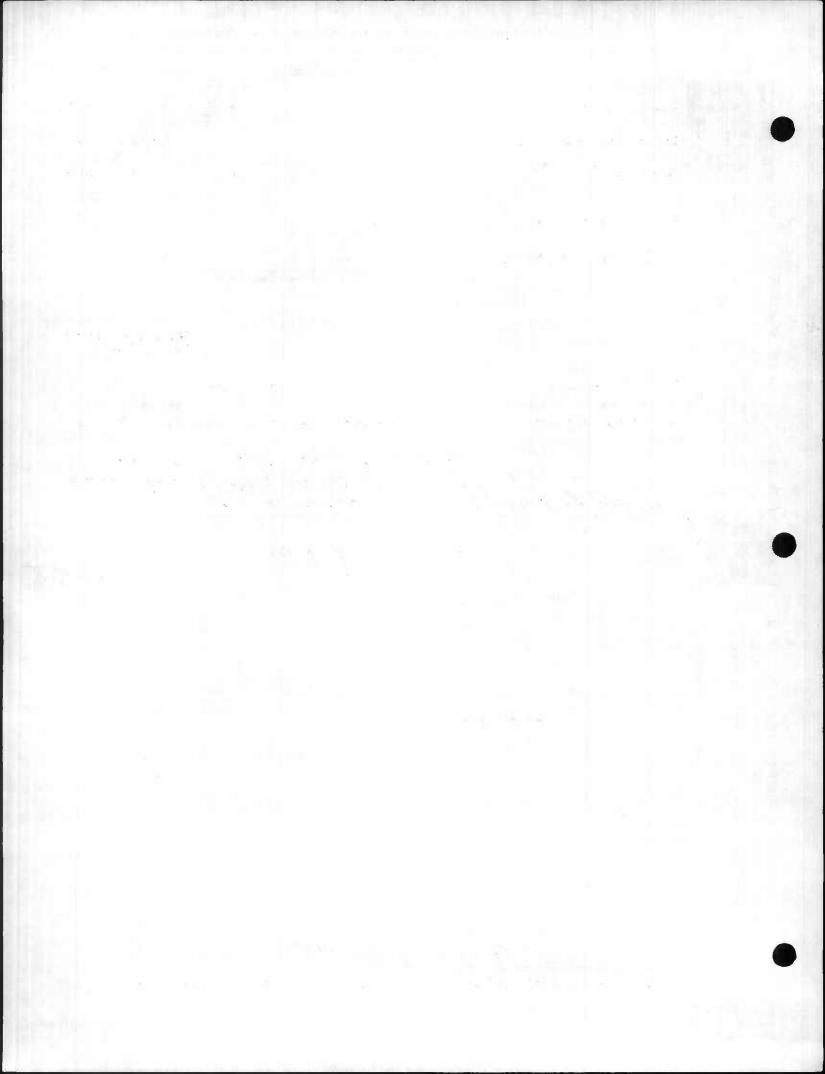
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Certificate of 1. Decedent's Name (First, Middle, Last)	Death 2. Dete of	Reg. No. Deeth 3. Time of Death
hysician /Medical	John J. Brennan	Month March	1 4, 1999 Year 9:30 am
aminer		4b. City, Town, or Location of Do	IA
	Laurel Regional Hospital 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) if Under 1 Year	Laurel If Under 24 Hrs. 8 Date of	Prince George's
ral tor	209-18-3196 1 AM 2 F 74 Yrs. Months Days	Hours Min. (Month, Dec.	Birth 9. Birthpiece (State or Foreign Country) 10, 1924 Pennsylvania
	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
lor	MD Prince George's Beltsvlle		1 ☐ Yes 2 反 No
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Whet Country?
al D	3123 Chapel View Drive 2070	05	USA
luny or other treumatic event, the Modical Evantue. To Be Completed by Funer		Hispanlc Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:	No- 14. Rece - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education 16a. Decedent's Usuel Occup	pation	16b. Kind of Business/Industry
	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Microbiologis	t	State of Maryland Health Dept.
	17. Fether's Name (First, Middle, Last) Patrick Brennan	18. Mother's Neme (First, Mid Lucy White	
	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street	t and Number or Rurel Route Nu	mber, City or Town, Stete, Zip Code)
			tsville, MD 20705
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other pla Mother of Sorrows C		20c. Location - City or Town, State Carbondale, PA
	21. Signature of Funeral Service Licensee 22. Name and Addre Home, Inc. Silver Spi		J. Collins Funeral y Blvd, West
dical Examiner	Immediate Cause (Final disease or condition resulting in deeth) e. Currents f Due to (or es a consequence of): b. Due to (or es e consequence of):	fiver.	one Month
	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of):		
Priysicianime	Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse gi	iven In Part I. 23b. I	Did tobacco use contribute to the cause of death?
-	framoneg.		I Yes 2 No 3 Probably 4 Unknow
			Vas en eutopsy erformed? 24b. Were eutopsy findings availeble prior to completion of cause of deeth?
			Yes 2 No 1 Yes 2 No
o Be	25. Wes case relerred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpetient 3 □ DOA Ot	26. Plece of Death (Check or her:	nly one) Residence 6 □Other (Specify)
Certification: T	27. Manner of Deeth 1 (Z Neturel 5 Pending Injury (Month, Day Year) 2 Accident Investigation 28e. Dete of Injury (Month, Day Year) 3 Accident 28e. Injury WC 1		ibe how injury occurred
Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, Ierm, street, factory, office building, etc. (Specify)	28f. Locati City or	on (Street and Number or Rural Route Number, Town, State)
edicai	29a. Certifier (Check only one) 117 Certifying Physician: To the best of my knowledge, death occurred et the ti 2		
×	29b. Signeture end title of certifier 29c. Licen		29d. Date signed (Month, Day, Year)
	That I was	4283	3.4.99
	30. Name and eddress of person who completed duse of deeth (Item 23e) (Type, Print)		
	Yusuf Muhammad, MD. 3450 Ft. Meade Rd., #109 31. Dete filed (Month, Day, Year) 32. Registrer's Signature	, Laurel, MD 2	0724-2040
State istrar	31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature 9. Spans	2	

DHMH 16 Rev 6/95

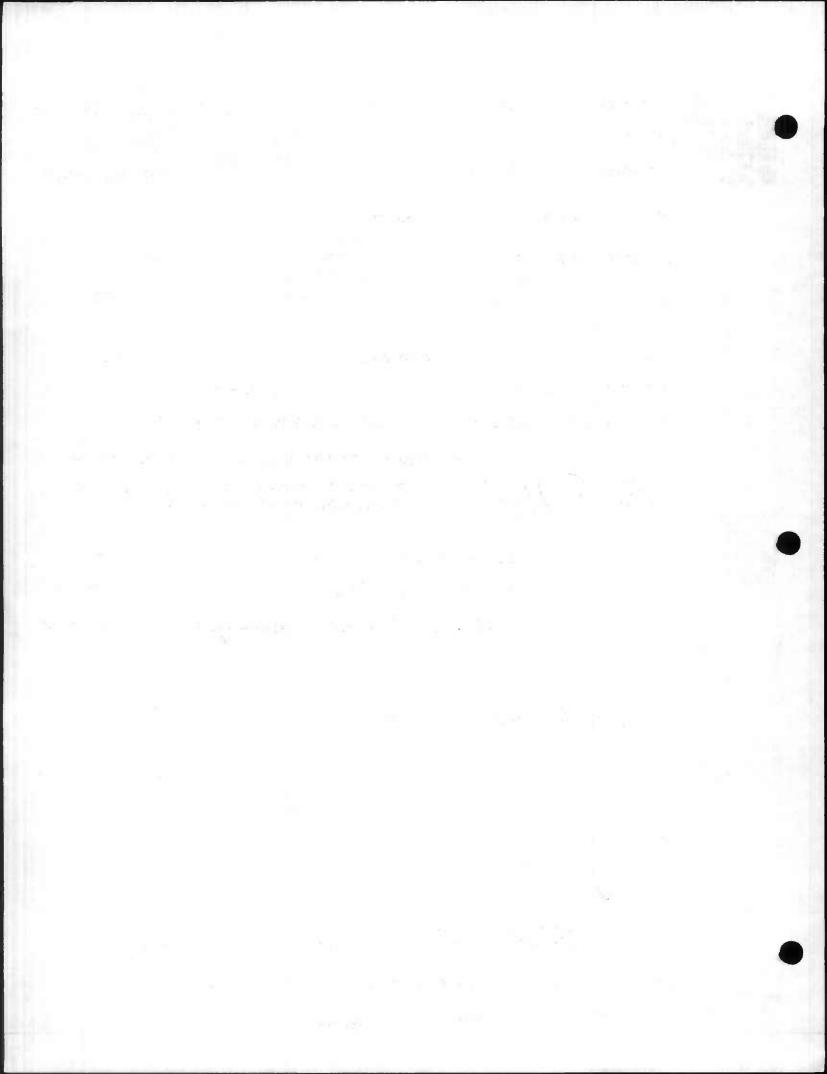


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physiclan** FRANCES KEARBY BON 1, 1999 MARCH 5:50 am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** WILLIAM HILL MANOR EASTON TALBOT 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗓 F 101-07-8794 Yrs Director DEC. 12, 1911 WASHINGTON Usual Residence of Decedent the Marylend 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD 1 N Yes 2 No TALBOT EASTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 501 DUTCHMAN'S LANE death Funeral 21601 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or then any Injury or other traumatic event, the Medical Exercises. 1 Never Married 2 ☐ Merried 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Yes 2 X No Specify: WHITE Specify: à 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DELBERT OSCAR KEARBY ALICE ALBERTSON 19a. informant's Neme/Relationahlp (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEARBY BON PARKER/DAUGHTER 6850 COOKE'S HOPE ROAD, EASTON, MD 21601 Baltimore, 20b. Place of Disposition (Neme of cametery, crematory or other placa) Date 20c. Location - City or Town, State 1 ☐ Buriel 2XXX remation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR. 3-2-99 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line. Intervel Between Onset and Death Physiclan /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner ician and burial-transit 10mgo be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last physician s the burial Box 68760. 40 1 Physician/Medical Due to (or es a consequence of) 98 o signed by the at d be detached fo Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certific. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other:

Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA funeral 28c. Injury af Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 ☐ Could not be determined To the Hospital or Attawithin 24 hours efter decorate to the Funeral Director completely filled in by the 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred of the time, date and placa, and due to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and fitle of 29d. Date signed (Month, Day, Year) Ma L D25750 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) ROBERT B. SANCHEZ, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 02 1999



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Physician	1. Dec	edent's Nama (First, Middla, La	ist)				2. Data of De	eath		3. Tima of Death	
i ilysiciali						0.00	Month	Day	Year		
/Medical		David Lawrence	_				MARC		1999	5:02 PM	
Examiner	400	cility Nama (If not institution, giv	11	10 -		City, Town, or Loc	ation of Deat	h 4c. County	oi Death		
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ineral			SZI 14 OFF	Months		Hours Min.	8. Data of Bir (Month, Da	ly, Year)	Counti	aca (Stata or Foreign	
ctor		Rasidance of Decedant	3.	3 113.			Oct. 3	1965	Mary.	Land	
dical Essering must be notified at sted by Funeral Director	10a. S		10c. C	City, Town or Location	-				10	d. Inside City Limits	
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Director	10a S	treet and Number			in Code		- 1	10a Citizan of I	What Count		
0 2 0								10g. Citizen of What Country?			
ara la		308 Palmetto I		110	210			USA			
Funeral	11. Ma	ritai Status	12. Was Decedent Evar in I Armed Forcas?	If Yas, spe	ecify Cuban,	panic Origin? (Spec Maxican, Puarto F	Rican, atc.)	Bla	ce - Amarica ck, Whita, a		
by		Nevar Married 213 Married Widowed 4 Divorced	1 ☐ Yas 2 XNo If Yas, Giva	1 🗆 Yas	25 No	Specify:		Specif	v: Wh	ite	
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Completed		15. Decedent's E (Specify only highast gra	ducation ada completed)	16a. Decedent's Use (Giva kind of w	ork dona du	on ring most of workin	g	16b. Kind of B			
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Be									ila)		
2	•						ella Jones				
		nformant's Name/Ralationship (19b. Mailing Addras					, Stata, Zip (Coda)	
		aren M. Boyd/W				Drive, Ed			1040		
		athod of Disposition ☐ Burial 2 ☐ Cramation 3 ☐		Placa of Disposition (Na cematary, cramatory or	ama of othar place)		Data	20c. Location	- City or Tow	vn, Stata	
		☐Donalion 5 ☐Othar (Specif		. Zion UM C		ry 3/	/6/99	Bel Ai	r, MD		
*	21. Sk	potung of Funeral Sarvice Lice	psee /		and Addrass						
puce	D	1 1 1 10 /16	and oth	Howar	ed K. 1	McComas]	III Fur	neral Ho	me, P	.A.	
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	5	Parti. Entar tha diseasa, or com hock, or haart lailura. List only	one causa on each line.	ati. Do not ental tha mo	or dying,	Such as Carolac of	raspiratory a	mest,	1	Interval Batween Onset and Death	
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CEEL & - MAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth 5,1999 3:05 A.M. 4b. City, Town, or Location of Death Ronald Homer Blackstock 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. May 17 29, Year 943 7. Age (In yrs. last birthdey) 55 Yrs. 9. Birthplace (State or Foreign County) ichigan 5. Social Sacurity Number 1 M 2□F 375-42-3407 Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No West Virginia Berkley Martinsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Route 5, Box 352 25401 U.S.A. 12. Was Decedent Ever in U.S. Amed Forcas? 1∑ Yas 2□No 1968 to If Yas, Giva Yaar or Datas: 1971 Was Decedent of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indien, Black, Whita, atc. 11. Marital Status 1 Navar Married 2 Married White 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16h Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Salesman Steel Manafacturing Co. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middle, Last) James E. Blackstock, Sr. Christine Kote 19e. Intormant's Name/Relationship (Type, Print) Nancy Blackstock/Wife 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Gode) Route 5, Box 352, Martinsburg, W. Va. 25401 20b. Place of Disposition (Nama of 20e. Mathod of Disposition Date 20c. Location - City or Town, Stata March 6, 1999 Smithsburg, Md. 1 Buriai 2 Cramation 3 Ramoval from Stata Smiths Burgo Crematory 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funaral Sarvica Licapsas 22. Nama and Addrass of Facility Keeney & Basford Funeral Home 23a. Part1. Entar the disease, or complications that causad the death. Do not entar the mode of dying, such as cardiac or respiratory errest, Approximeta shock, or heart failure. List only one cause on each line. Approximeta Interval Batwean Onset and Death Immediata Causa (Final disaasa or condition rasulting in death) DISSEMINATED INTRAVASCULAR CONGULATION WEEK Due to (or es e consequence of): Due to (or es e consequence of): GASTRUC ADENO CARLINOM A Due to (or es e consequence of): 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yas 2□ No 3□ Probably 4□ Unknown 24b. Wara autopsy findings available prior to complation of cause of deeth? 24a. Was an eutopsy performed? 25. Wes case ratarred to medical axaminar? 26. Piece of Deeth (Chack only one) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

attending physician

as usa

should be detached

director,

funeral

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or Attending Physicien: after death. Director: After this certific

To the Hospital within 24 hours a To the Funeral C Hospital

certificate be executed physician and the burial-trans

Box 68760,

Division of Vital Records,

Physician

Examiner

Funeral

Director

itam 27 le marked other than "natural", or itema 23a or 28a-f ahor other traumatic event, the Medical Examinar must be northed at

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Haalth and Mental Hydiena. important: if item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Medical Examinations.

altimore, Maryland 21215-0020

with the Maryland

/Medical

10a. Stete

Directo

Funeral

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Completed

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Examiner

Physician/Medicai

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Certification:

Medical

Sequantially list conditions, if eny, leading to immadiata cause. Enter Underlying Causa (Disease or Injury thet initieted evants rasulting in death) Last

27. Mannar of Death

1 Natural 2 Accidant

3 ☐ Suicida

29e. Cartifia

4 Homicida

(Check only one)

Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28d. Dascribe how injury occurred

28b Time of 28c. Injury at Work? 1 Yes 2 No

Cartifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and maintened at the time, date end piece, and due to the cause(s) and maintened at the time, date and piece, and due to the cause(s) and manner stated.

MA

5 Panding

investigation 6 Could not be datarminad

> 29c. Licanse number D31761

29d. Data signed (Month, Day, Year)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

30. Neme end addrass of person who complated causa of daath (Itam 23a) (Type, Print)

28a. Deta of Injury (Month, Dey Year)

501 W. SEVENTH ST. FREDERICK MD Of CONNOR MA

State Registrar 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month 05, BEERS March 1999 7:45 Grier William . /Medicai 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 329 Selwyn Drive, Unit 1-A Frederick Frederick H Under 24 Hrs.
Hours Min.

8. Date of Birth (Month, Day, Year)
Mar 19, 1925 Pennsylvania 6. Sex 1 ☑ M 2 ☐ F If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Months Deys 73 210-12-0279 Yrs. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1. Yes 2 No Director 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 21701 U.S.A. 329 Selwyn Drive, Unit 1-A Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 DXYes 2 DNo If Yes, Give Year or Dates: WW II 1 Never Married 2 N Married 1 ☐ Yes 2X No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Public School Teacher Education 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Name (First, Middle, Last) Be **BEERS** Eula KRISE Roy 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Peggy M. Killen Beers/Wife 329 Selwyn Drive, Unit 1-A, Frederick, MD 21701 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Smithsburg Crematory Mar 6,1999 Smithsburg, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home 21. Signature of Funerel Service Licenses spaser M00706 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enter the issesse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Immediete Ceuse (Finel diseese or condition resulting in deeth) ATRIAL IYK FIBRILLATION Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown EURAL EFFUSION, VOD-BASEDOW DISEASE, þ Completed 24e. Was en autopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? DIVERTICALOSIS, ANEMIA PARA PARESIS 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Couid not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steled.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steled. ical 29a, Certifier Medi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ndraw O. Which D21936 March 5, 1999 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Andrew O. Donelson, M.D., 170 Thomas Johnson Dr, Suite 100, Frederick, MD 21702

State Registrar

Funeral

Director

show

288-4

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items 23a

"natural", or

Peges 1 and 2 should be filed within nent of Health and Mentel Hygiene. Int: If item 27 is marked other than "arry or other traumatic event, the Medium of the manufacture and the Medium of the Mediu

Department of Important: If any injury or

Physician /Medical

Examine

The law requires that the death certificete be executed

Box 68760,

P.O.

Division of Vital Records,

-transit

the

signed l

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica stely filled in by the funeral director, I

To the Hospital of within 24 hours of To the Funeral Completely filled

end

72 hours efter

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

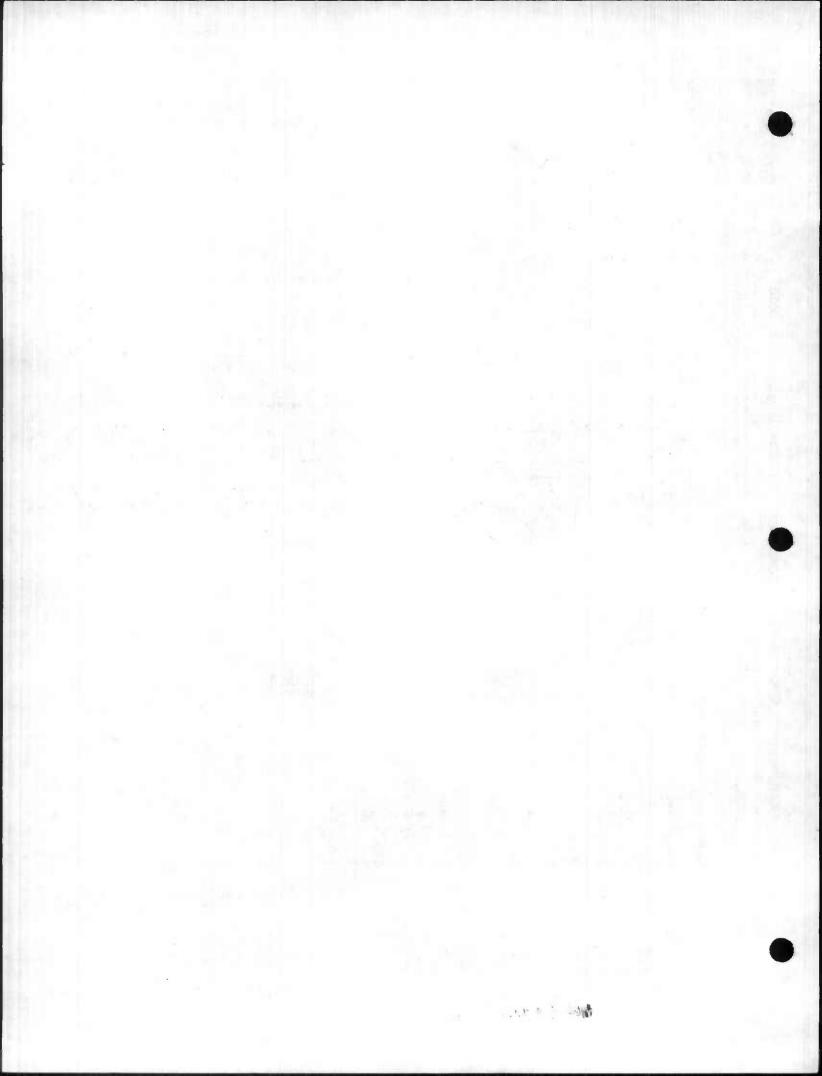
31. Dete filed (Month, Day, Year) 0 8 1999 32. Registrer' Signeture



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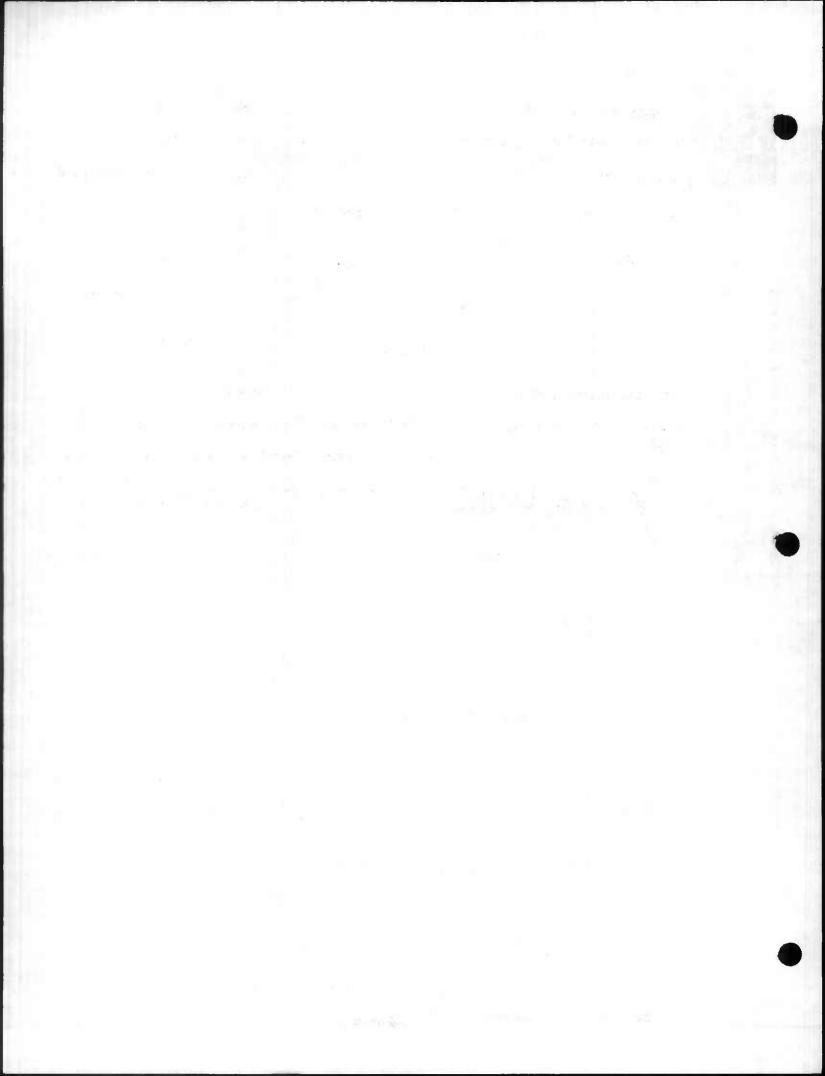
State of Maryland / Department of Health and Mental Hygiene 9 0 8 4 1 6

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	1. Decedent's Nama (First, Middla, L	ast)	Sept 10		2. Data of Death)	3. Tima of Dea				
Physician	PAUL LEO	BEALL, SR.			March 5	, 1999	Year 5:20A.1				
/Medical Examiner	4a Facility Nama (If not institution, g.			4b. City, Town, or	Location of Death	4c. County of	of Death				
LAdiiiiiei	10725 Dayswi	11a Dood		T . 1	1						
	10735 Daysvi 5. Social Security Number 6.		. last birthday) If Unde	Freder	8. Data of Birth		9 Birthplace (State or Fo				
uneral lirector	E70 /0 2100	. (Month, Day,	(Month, Day, Year) Country)								
il cotol	578-40-2188 Usual Rasidanca of Dacedant	Nov. 30	Nov. 30, 1921 Maryland								
B u	10a. Stata 10b. County	10c. Ci	ity, Town or Location			10d. Inside					
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be notified	Maryland Freder 10e. Street and Number	1CK F	rederick	p Code	10	g. Citizen of W	hat Country?				
D 50		D 1									
M 23	10735 Daysville	ROAD 12. Was Decedent Ever in U		21701		United	- Amarican Indian,				
Fur Par		Armed Forces?	If Yes, spe	ident of Hispanic Origin? (S acity Cuban, Mexican, Puar	to Rican, atc.)		, Whita, etc.				
Exami	1 Nevar Married 2 Married 3 Widowed 4 Divorced	If Yas, Giva	1□ Yes	2) No Specify:		Specify:	**1				
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nation and a section of the section	15. Decedant's E (Specify only highast g	ada completed)	16a. Decedent's Usu (Give kind of w	ork done during most of wo	orking	6b. Kind of Bus	inass/industry				
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S B	12		Operating	Engineer			Crough Co.				
arked oth artic even To Be	17. Fathar's Nema (First, Middla, Las	me (First, Middle, M	aiden Sumama	J)							
	William Leroy	e Gill									
E S	19a. Informant's Name/Reletionship		19b. Mailing Addres	s (Street and Number or R	ural Routa Number,	ber, City or Town, Stata, Zip Code)					
127 er tr	Ruth Alice Bea	11, wife	10735 Da	ysville Road	Frederi	ck, Mar	yland 21701				
and di	20a. Method of Disposition	206. 1	Place of Disposition (Na cemetery, crematory or	ma of other place)	Date 2	20c. Location - City or Town, Stata					
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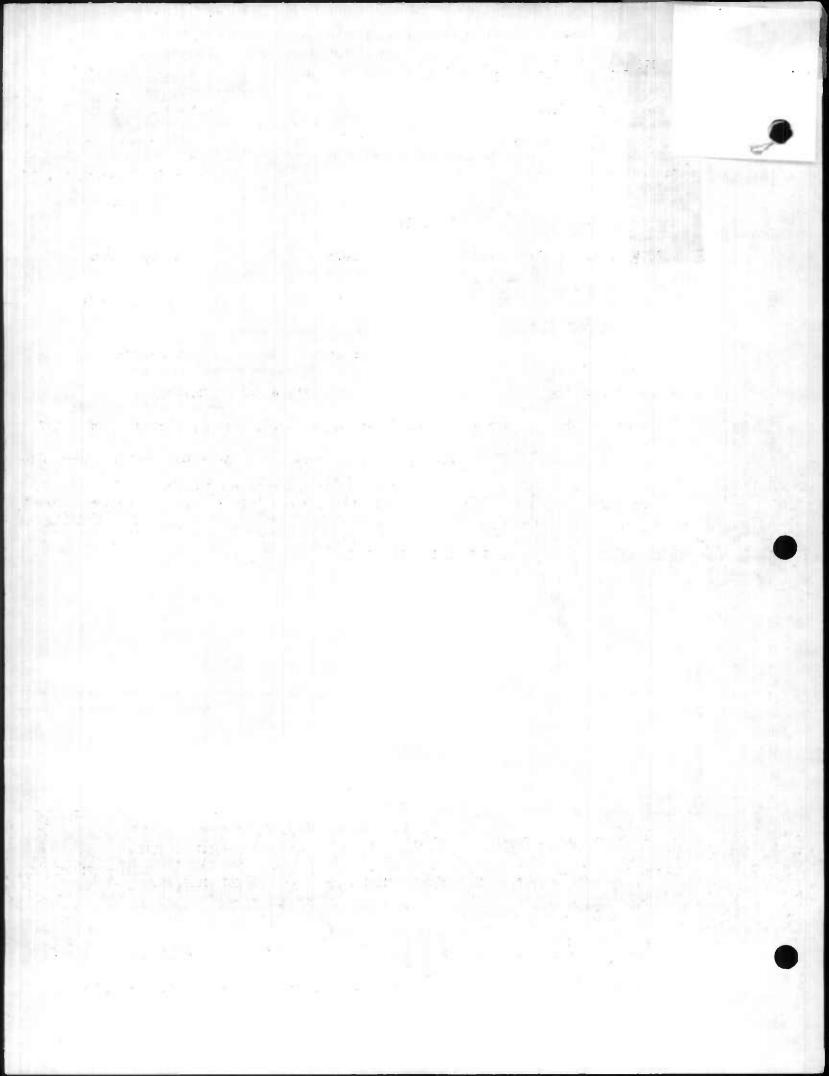


State of Maryland / Department of Health and Mental Hygiene

						Certific	ate of	Death		Re	g. No.	UD	19.1	1	
	Division		1. Decedent's Name (First, Middle, La	st)						2. Date of Death	1	Yeer	3. Tim	f Death	
U	Physici /Medi		MARY MOFFETT	BRYDEN						FEB 27,	1999	1661	2 11	1	
	Exami		4a. Fecility Neme (If not institution, giv	e street end number)						cation of Death	4c. County	of Death			
			Magnolia Hall Nur	sing Cente	r			Chest	erto	wn	KENT				
7	Funeral Director		5. Social Security Number 6. S 220 26 1855 Usuel Residence of Decedent	ex 7. Age □ M XX F 8	(In yrs. lest bir	thday) If Un Mont	hs Days		Min.	8. Date of Birth (Month, Day, Dec. 25,	^{Year)} 910	9. Birthpl Count Mar	lace (Stete try) yland	or Foreign	
	Maryland 4 show	tor	10a. State 10b. County Md. Kent		10c. Cily, Tow Rock I	n or Location	(Kent	Co.)				10	0d. Inside (City Limits	
	the 28a	Director	10e. Street end Number			10f.	Zip Code			10	a. Citizen of V	Whet Coun	Irv?		
	h with		Main St.			2	1661				USA		•		
Maryland 21215-0020	n 72 hours after death with the Maryland *natural*, or Items 23s or 28s-f show sorcal Expresser must be notified at	by Funeral	11. Maritel Status 1 ☐ Never Married 2 ☐ Married Widowed 4 ☐ Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No Il Yes, Give Year or Dates:		13. Wes De	ecedent of	en, Mexican,	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	Blee	e - America ck, White, e ,: Whit	etc.		
2-0	72 ho natur	eted	15. Decedent's Ed (Specify only highest gre	ducation	16a.	Decedent's L	Jsual Occu	pation during most	of workin	1	6b. Kind of Br	usiness/Ind	lustry		
121	d within plane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		' <i>iife. DO NO</i> lerk	T use retire	ed)	Or WORK	-	Store				
d 2	be filed vital Hygis of other filed	ပိ	17. Fether's Neme (First, Middle, Last)	1	U.	ierk		18. Mother	r's Name	(First, Middle, M	leiden Surner	10)			
an	od ita	o Be	******	66 44				Anna				,			
37	d 2 should th and Mer 7 Is marks traumatic	J.	William Simon Mo		19b	. Mailing Addr	ress (Stree			l Route Number,	City or Town.	Stete. Zip	Code)		
	1 and 2 Health a am 27 Is		Thelma Moffett Va	ngant		05 Map1				town, Mo					
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 900.		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of the content	Removal from Stete	20b. Place of	Disposition (Neme of or other ple	ca)	1		Rock				
Balti	permit. Departm Importar any inju		21. Signature of Euneral Service Licer),	22. Neme Willi	end Addr	ess of Facility	nera	1 Service	e_	Hero			
	- Physician		23a. Pert . Enter the diseese, or com sho , or heart feilure. List only	plications that caused I one ceuse on each line	he death. Do	not enter the r	mode of dy	ing, such es d		p 21620 r respiratory arre	,		Approxima Intervel Be Onset end	ate etween	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	· PNE	umon	IA							Zda	WS.	
		ē		0	ue to (or as a	consequenca	of):					1		,	
	tificata be axecuted g physician and as the bunal-transit	Examiner	Sequentially list conditions,	b	ue to (or es e	consequenca	ol):								
60,	be ay		if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	c											
x 68760,	n certificata be axecuted anding physician and usa as the bunal-transit	/Medical	that initieted events resulting in deeth) Last	d	ue lo (or es e d	consequenca	of):					1			
000		clar													
o.	that the death led by the atter detached for o	ıysi	Part II. Other significant conditions of		_	_	ng cause gi	ven in Pert I.			acco use co				
7.	es that the igned by th be detache	by Physician/	CONGESTIVE	HEART F	AILU	RE				1 Ye	8 28 No	3 Prob	ably 4	JUnknown	
or vital Records,	requir	Completed b									24a. Was an autopsy performed?			lindings to cause	
ř	The law ata has b paga 2 s	mo								1 ☐ Ye	s 2XNo	1	Yes 🏠	No	
<u>e</u>		Be	25. Was case referred to medical examiner?					26. Place	ol Deeth	(Check only one	9)			•	
>	Physician: r this certific rral director,	1º	1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Ou	utpetient 3	DOA Ot	her: 4 Nur	sing Hon	ne 5 🗆 Reside	nca 6 □Oth	er (Specify	1)		
	Ing P	on:	27. Manner of Deeth 1 Naturel 5 ☐ Pending	28e. Dete of Injury (Month, Dey		Time of njury	28c. Inju Wo			28d. Describe ho	w injury occur	red			
DIVISION	or Attending after death. Director: After In by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	(Month, Dey Year) Injury Work7 1 □ Yes 2 □ No 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rurel Route Numb City or Town, State)				
ב	To the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral	edical Ce	(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e	examination an	, deeth occurr d/or investiget	red el the li	me, date and	l placa, e	nd due to the ca	use(s) end ma	anner es st	eted. the ceusei	(s)	
	the the	Med	onej	end menner stale	ed.										
	D W D		29b. Signature end title of certifier	A Mobile	hus		29c. Licen	9 415	87	28	d. Date signe	195	Jay, 19ar)		
			30. Neme and address of person who	completed cause of dec											
			Helen A. Noble	122 Speer	Noau	hester	cown,	Md. 2	1620						
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1									



ician	1. Decedant's Nama (First, Middla, La	ist)		epartment of Certificate o		2. Data of De Month		3. Time of Death
aicai	Jeffrey Pier					Februa	ry 21, 1	999 1:15 P.M.
niner	4a Facility Nama (If not institution, giv	and the same of th			4b. City, Town, or L		- 1 - 11 - 1	
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		10XM 2□ F		rs. Months Day		8. Data of Bir (Month, Da May 18	y, Year) 1954	9. Birthplaca (Steta or Foraign Country) Washington, DC
H	10a. Stata 10b. County		10c. City, Town	or Location				10d. Insida City Limits
ctor	Maryland Howard		Elkrid	ge				1 Tas 2 No
Dire	10e. Street and Number			10f. Zip Code			10g. Citizan of W	
a a	6620 Washington			21075			United S	
3	11. Marital Status 1 XNevar Married 2 Married	12. Was Decedant Ev Armed Forcas?		13. Was Decedant o	of Hispanic Origin? (Sp uban, Maxican, Puarto	ecify Yas or No Rican, atc.)	Black	- Amarican Indian, k, Whita, etc.
	3 Widowed 4 Divorced	1 ☐ Yas 2 ☐XNo If Yas, Giva Yaar or Datas:		1□ Yas 2₺N	lo Specify:		Specify:	White
	15. Dacedant's E	ducation	16a. C	Decedant's Usual Occ	cupation na during most of work		16b. Kind of Bus	sinass/Industry
-	(Spacify only highast gra Elamantary/Secondary (0-12)	Collaga (1-4or 5+		life. DO NOT use rati	ired)	ung		
Description	8			Labore			Constru	
	17. Fethar's Name (First, Middla, Last,)					Maidan Sumame	a)
	Edmund Scott Cox 19a. tnformant's Name/Reletionship (Time Print	104	Mailing Address /Com	Florence			State Zin Code ¹
	Florence May Cox	(mother)						
	20a. Mathod of Disposition	(motner)		ZU WASNINE Disposition (Nama of r, cramatory or other p	gton Blvd,	Lot #9		ge, MD 21075 City or Town, Stata
	1 ☐ Burial 2 【X Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			eake Crema				lle, Maryland
	21. Signatura of Funaral Sarvice Licar		onesap	22. Nama and Ado	drass of Fecility			ine, maryiand
To Be Completed by Physician/Medical Examiner To Be Completed by Funeral Director) Co = 0 0	M 0	eral Servic Avenue, S			aryland 20910		
er	23a. Part1. Enter tha disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	BLUNT FO	1.	IES OF HEAD	nying, such as cardiac	or raspiratory a	rrast,	Approximate Interval Batween Onsat and Daath
	Sequentially list conditions.	b	oua to (or as a co	onsequenca ot):				
	if any, taading to immadiate							
5	Sequantially list conditions, if any, taading to immadiate causa. Entar Undartying Cause (Disease or injury that initiated events rasulting in death) I ast	c	ua to (or as a co	onsequance of):				
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lan/Medical Examiner	causa. Entar Undarrying Cause (Disease or injury that initiated events rasulting in death) Last	d			civan in Part I	23b. Did	tabacco uae con	tribute to the cause of death
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o Be Completed by Physician/Medical Examiner	causa. Entar Undarrying Cause (Disease or injury that initiated events rasulting in death) Last	d			givan in Part I.	1 🗆 24a. Was		
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edical Certification: To Be Completed by Physician/Medical Examiner To Be Completed by Funeral	Cause (Disease or injury that initiated events rasulting in death) Last Part II. Other significant conditions of the co	d	not resulting in	tha undarlying causa	26. Placa of Daa Other: 4☐ Nursing H	1 24a. Was perfe	Yes 2□ No an autopsy rmed? Yas 2□ No ona)	3 Probably 4 Unknow 24b. Wara autopsy findings available prior to complation of cause of death? 1 Yas 2 No ar (Specify) AT SCENE
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Medical Certification: To Be Completed by Physician/Medical Examiner	Cause. Entar Undarrying Cause (Disease or injury that initiated events rasulting in death) Last Part II. Other significant conditions of axaminer? 1 Syas 2 No 27. Manner of Death 1 Nature 5 Panding Invastigation 3 Suicide 6 Could not b detarmined 29a. Cartifiar 1 Certifying Ph	Hospitat 1 Inpatian 28a. Dete of Injury Found: 9ay 28a. Place of Injury building, etc.	t 2 ER/Outp (Year) 28b. Till Ound 1: y-At homa, farr (Specify) ABANDONED my knowledga,	tha undarlying causa patient 3 DOA me of pury P 28c. In ury P 10 M 1 m, streat, factory, offic BUILDING	26. Placa of Daa Other: 4 Nursing H sjury et Vork? Yas 2 No	24a. Was perform 1 24b. (Chack only of the Chack only only only only only only only only	Yes 2□ No an autopsy primed? Yas 2□ No pna) dence 6 (MOtha how injury occurred and Number win, Stere) 102 LE, MD. causa(s) and mer	3 Probably 4 Unknow 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No It (Specify) AT SCENE ar (Specify) AT SCENE AT SCENE AT SCENE AT SCENE AT OF Rural Route Number, 11 BALTIMORE AVE.
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	Cause Disease or injury that initiated events rasulting in death) Last Part II. Other significant conditions of the con	Hospitat 1 Inpetian 28a. Dete of Injury Found 2-21-99 28a. Place of Injury building, etc. FOUND IN yelclan: To the bast of	t 2 ER/Outp (Year) 28b. Till Ound 1: y-At homa, farr (Specify) ABANDONED my knowledga,	tha undarlying causa patient 3 DOA me of Pury P 00 M 1 m, streat, factory, office BUILDING daath occurred et the for Invastigation, in my	26. Placa of Daa Other: 4 Nursing Hi jury et Vork? Nork? Yas 2 No De Itime, data end pteca, y opinion, deeth occur	24a. Was performed to the community of the control	Yes 2□ No an autopsy primed? Yas 2□ No ona) dence 6 (MOtha how injury occurred ASSAULTED Street and Number More, Stere) 102 LE, MD. causa(s) and mer date and plece, a 29d. Data signed	3 Probably 4 Unknow 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No It (Specify) AT SCENE ar (Specify) AT SCENE It BALTIMORE AVE. Inner as steled. Ind dua to the cause(s)
edical celumeaton: 10 ce completed by any social amountain	Cause (Disease or injury that initiated events rasulting in death) Last Part II. Other significant conditions of axaminer? 1 Yas 2 No 27. Manner of Death 1 Naturel 5 Panding Invastigation 3 Suicide 4 Homicide Getarmined 29a. Cartiflar (Check only one) 29b. Signatura and titla of certifler	Hospitat 1 Inpetian 28a. Dete of Injury Found 2-21-99 28a. Place of Injury building, etc. FOUND IN yelclan: To the bast of	t 2 ER/Outs (Year) 28b. Till Ound 1: y-At homa, farr (Specify) ABANDONED my knowledga, mamination and/ad.	tha undarlying causa patient 3 DOA me of pury P 0 M 1 m, streat, factory, office BUILDING death occurred et the for Invastigation, in my	26. Placa of Daa Other: 4 Nursing History et Vork? Yas 2 No ce etime, data end pteca, y opinion, deeth occur	24a. Was performed to the community of the control	Yes 2□ No an autopsy primed? Yas 2□ No ona) dence 6 (MOtha how injury occurred ASSAULTED Street and Number More, Stere) 102 LE, MD. causa(s) and mer date and plece, a 29d. Data signed	3 Probably 4 Unknow 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No If (Specify) AT SCENE and If BALTIMORE AVE.
edical Certification: To be Completed by Physiciary Medical	Cause (Disease or injury that initiated events rasulting in death) Last Part II. Other significant conditions of axaminer? 1 Yas 2 No 27. Manner of Death 1 Naturel 5 Panding Invastigation 3 Suicide 4 Homicide Getarmined 29a. Cartiflar (Check only one) 29b. Signatura and titla of certifler	Hospitat 1 Inpetian 28a. Dete of Injury (Manth. Day 2-21-99 28a. Place of Injury building, etc. FOUND IN Insert On the basis of a and mannar state	t 2 ER/Outs (Year) 28b. Til Outs (Specify) ABANDONED my knowledga, examination and ad.	tha undarlying causa content 3 DOA one of pury P 1 DING death occurred et the for Invastigation, in my 29c. Lica	26. Placa of Daa Other: 4 Nursing History et Vork? Yas 2 No ce etime, data end pteca, y opinion, deeth occur	24a. Was performed to the Chack only of the Chack only only only only only only only only	an autopsy ormed? Yas 2□ No Ona) dence 6 (X)Otha how injury occurred ASSAULTED Street and Numbe on, Steet) 102 LE, MD. 29d. Data signed	3 Probably 4 Unknow 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No ar (Specify) AT SCENE and are as steled. In a steled. In



	e, 3	3/9/99/BMW, Montg.		laryland / Depa Cei	tificate c		- Wieman Try	Reg. No.	08419		
	_	1. Decedent's Name (First, Middle, I	ast)				2. Date of De	eath	3. Tima of Death		
Physicia: /Medica	_	NELLY OESCHGER	CADELL				Month MARCH	1, 1999	2:27PM		
Examine		4a Facility Name (If not institution, g	ive street and number;)		4b. City, Town, o	r Location of Deat	h 4c. County	of Death		
		MONTGOMERY GENERA	AL HOSPITAL			OLNEY		MONTO	OMERY		
Funeral Director		5. Social Security Number 6. 577-12-7493 Usual Residence of Decedent	Sex 1 □ M 2 ☑ F	ge (In yrs. last birthday) 79 Yrs.	If Under 1 Ye Months Da			ay, Year)	9. Birthplace (State or Foreign Country) SWITZERLAND		
ural, or thems 23a or 28a-f show is Examinar must be notified at		10a. State 10b. County	(TDV)	10c. City, Town or Lo					10d. fnside City Limits 1 ☐ Yes 2 ☑ No		
289	X -	MARYLAND MONTGOI 10e. Street and Number	1EKY	SILVER	SPRING 10f. Zip Cod			10a Citizen of V	. Citizen of What Country?		
0 0		7 Finsbury Pa	rk Court								
	by Funer	1921 HTCKORY HTL 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces	No	2090 Was Decedent of Yes, specify C	of Hispanic Origin? Cuban, Mexican, Pu			e - American Indian, k, White, etc.		
ther then "naturalism."	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4or	5+) (Give	lent's Usual Oc kind of work do OO NOT use red EWIFE	ne during most of w	rorking	16b. Kind of Bu	siness/Industry		
to b	e e	17. Father's Name (First, Middle, Lateral EMILE W. OESCHGE)		11003	EWIFE	18. Mother's N	ame (First, Middle				
E I	- -	19a. Informant'a Name/Relationship		19b. Mailir	ng Address (Str	eet and Number or		per, City or Town,	State, Zip Code)		
27 le		DIANE M. CADELL/	DAUGHTER	1921	HICKOR	Y HILL LA	NE SILVE	R SPRING	G, MD 20906		
nt: If Itam ry or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Special Control of Control	☐Removal from Stafe	20b. Place of Dispo	sition (Name of natory or other)	place)	Date 3/5/99		City or Town, State		
Important: If eny injury or pace.		21. Signature of Funeral Service Lic	. Domi	2 HI	NES-RIN 800 NEW		RE AVE. S	SILVER SE	PRING, MD 20904		
ysician ledical aminer		shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each li	ine.					fnterval Between Onset and Death		
	Examiner	resulting in death)	Pre	e Respira Due to (or as a consequencia	uence of):				23 days		
0 5	200	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf	. Sejsi	Due to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a co				674	5 claup		
the attending plant in the for use as the formula in the formula i	SICIBIL	Part ff. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause	given in Part I.	23b. Did	tobacco use co	ntribute to the cause of death?		
90	Dy Fin	atrial 3.	luter				- 10	Yes 2□No	3 Probably 4 PÓnknown		
a 2 should	paraidwon				<u> </u>		perfe	s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?		
certificate rector, per		OE Mine come information with the	T			20 20		Yes 2 No	1 ☐ Yes 2 ☑ No		
a certific director.		25. Was case referred to medical examiner?	Hospital:			Other	leath (Check only				
a la		1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpati	ent 2 ER/Outpatien	I BLI DOA	4 LI Nursing	Home 5 ☐ Resi	how injury occur			
al Director: After the of in by the funeral	TICATION	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	(Month, Da	in Year) Injury	M 1	njury at Work? I Yes 2 No	28f. Location (Street and Numb	er or Rural Route Number,		
		4 Homicide	building, et	c. (Specify)			City or To	wn, State)			
the Fun		29a. Certifier 1	thysician: To the best iminer: On the basis of and manner st	of my knowledge, death f examination and/or inv ated.	restigation, in m	e time, date and pla ly opinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)		
To the		29b. Signature and title of certifier			-	ense number			d (Month, Day, Year)		
5 F 0	3	IN.O. Ferris						Marela			

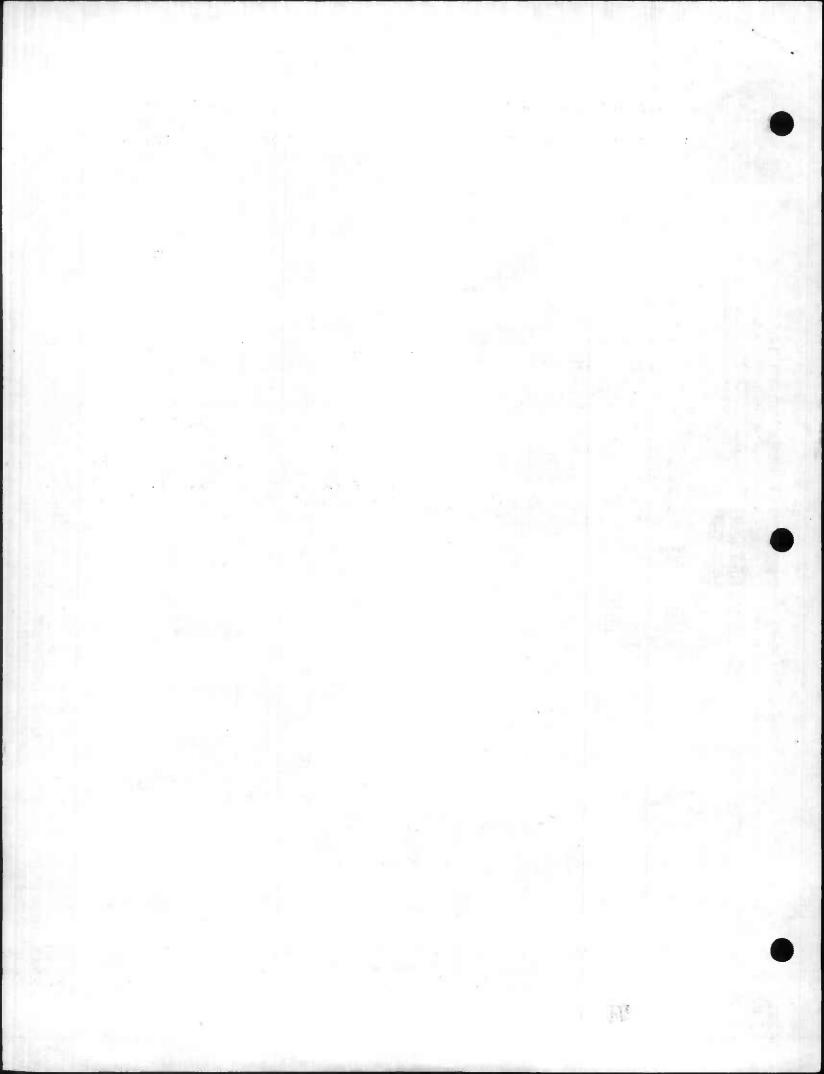
DHMH 16 Rev 6/95

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARREN 3- FERRS MD 3305 North Lessire World Society Selver Society Mary least 25906

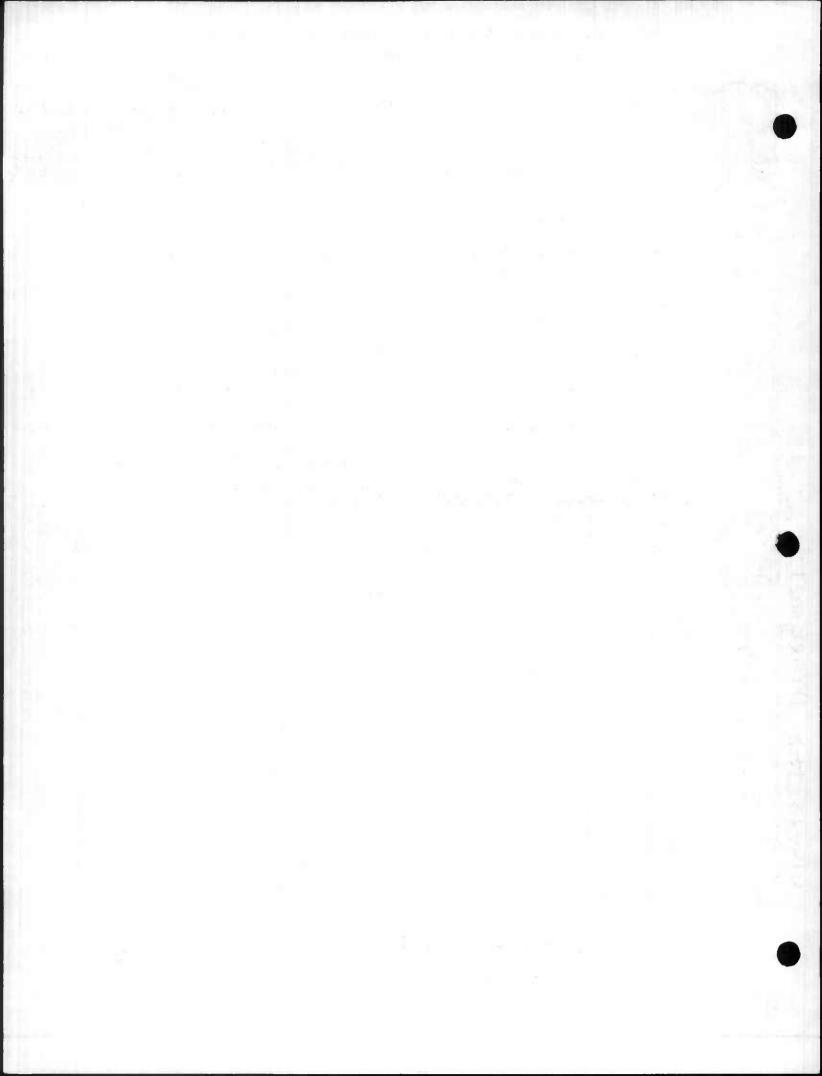
31. Date filed (Month, Day, Year)

1000 32. Physician's Storature



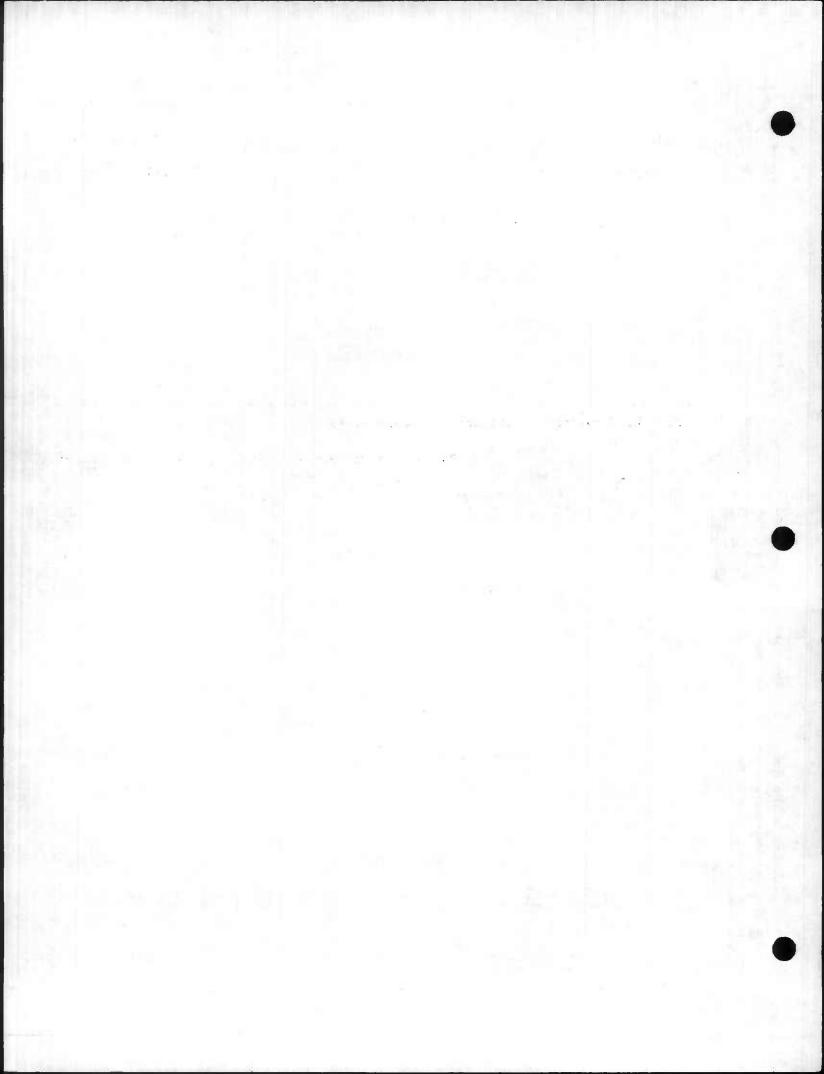
State of Maryland / Department of Health and Mental Hygiene

Physicia	n		e (First, Middle, Las GARET	•		OUT OUR	20000			2. Dete of De Month	Reg. No. eth Dey	Yeer	3. Time	Disith
/Medica	_			L.		CHICHES	STEK			Feb.	25	1999	2:19	T.M
Examine	er	4e. Fecility Neme (I	a management		ber)				4b. City, Town, or		and the second	1000		
	-	SUBUR 5. Social Security N	BAN HOSPI		Ano (In urr	lest birthdey)	If I Inde	er 1 Year	BETHES If Under 24 Hrs			rgome:		
uneral irector		577 01 Usuei Residence of	6363	_M 2∭F	10		Months				6,1898	Be I	Alton,	, MD .
Mon III		10a. Stete	10b. County		10c. C	ity, Town or Lo	ocation					1	0d. Inside C	Ity Limits
E E	Š	Maryland	Montgo	mery		Silver	Spr	ing					1X Yes	2□No
or 28a-f show be notified at	ire.	10e. Street and Nur	mber	10f. Zip Code							10g. Citizen of	Whet Cour	ntry?	
đ.	a	10000 E	Brunswick	Ave.,#106 2091					0		d States			
3	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3X Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 2↓ No				as Decedent of HispenIc Origin? (Specify Yes or No Yes, specify Cuben, Mexican, Puerto Rican, etc.) ☐ Yes 2X No Specify:				14. Race - American Indien, Bleck, White, etc. Multi Specify: Racial		
e d	Se l	/Snec	15. Decedent's Ed					petion	rkina	16b. Kind of B				
Mag	Be Completed	Elementery/Seco		College (1-4or 5+) life. DO NOT use retire						nny				
2	ទី	17 Fetheric Name	(Final Adiatella Land)	Gray Lady								Cross		
Important if item 27 is marked other than "n any injury or other traumetic event, the Med once. To Be Comple	Be		(First, Middle, Last) Charles N	ason					18. Mothers Nei	me (First, Middle, Mary B	ne)	9)		
		eme/Reletionship (7						t on at Alumbas as D			Chara Tin	0-4-1		
				ype, Print) 19b. Mailing Address (Streeter (Son) 75 East Wayn										
	-	20e. Method of Disp	position		20b.	Place of Dispo cemetery, cres	ast Na	wayn me of	e Ave.,#	Dete Dete	ver Spr 20c. Location	ing, City or To	MD . 20 wn, Stete	1901
			Cremetion 3 5 Other (Specify						emetery	3/4/99	Silver	Snri	ng MI	0
	1				/							OPII	g,	
B		21. Signature of Fungfal Service Licensee 22. Name and Address of Facility in CGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Washington										n, D.C. 20012		
	1	23a. Parti Enter th		lications that ca	uped the dear							n, D.		
ar;	+	23a. Parti Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, affock or heart failure. List only one cause on each line.									Approximate Interval Betwee Onset and Dea			
al		Immediate Cause (Final disease or condition CARDIAC ARREST									30 Min.			
er		resulting in death)		Due to (or as a consequence of):										
	e l			b	HEAR	T DISE	ASE						50 Yea	irs
	Examiner	Sequentially list our if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	nditions, mediate		Due to (or as a conseq	juence of)	T.						
1	100	cause. Enter Unde Cause (Disease or that initiated events	ritying	C	AGIN		· · · · · · · · · · · · · · · · · · ·							
1	edical	resulting in death) L	ant		Due to (d	or as a conseq	uence of):					- 1		
	2		•	d								-4		
	8	Part II. Other signifi	icant conditions co	otributing to dea	th but not rea	ulting in the u	ndertvina	cause of	von in Part I	23b. Did	tobacco use co	ntribute to	the cause o	of death?
fache the	Physician			ontributing to death but not resulting in the underlying cause give					1017 27. 7. 0012.1.		**			
	D.									1 ☐ Yes 2X No 3 ☐ Probably				
1	Del									24s. Was perfo	0.41	ere autopsy f silable prior t	D	
8 1	Completed									1,000			mpletion of o death?	ause
	5									10	Yes 2XINo	10	Yes 2	No
otor o	90	25. Was case referrexaminer?		re-source of the		10.00			The second limited and the second limited and the second	ith (Check only o	one)			
	2	1 ☐ Yes 2 🖄	NO	Hospital: 1 [] In		ER/Outpatier		UA		iome 5 Pesi		20000000	(r)	
	LOI I	1 X Natural	5 ☐ Pending investigation	28a. Date of (Month)	Day Year)	28b. Time of Injury	M	28c. Inju Wo	ryat rk? Yes 2 □ No	28d. Describe	haw injury occur	red		
1	Certification:	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not be	28e Place o	f Injury - At h	ome, farm, str	1,17711		169 57140	28f. Location (Street and Numi	ser or Rura	l Boute Num	ther
1	100	4 ☐ Homicide	determined		, etc. (Speci		ent, motor	y, union		City or Tox		POT OF FROM	r rising reason	Lieu,
	edical	29e. Certifier (Check only one)	1⊠ Certifying Phy 2□ Medical Exam	sicien: To the b tner: On the bas end manne	is of examine	owledge, deeth ation and/or In	occurred vestigation	fet the ti	me, dete end plece opinion, death occu	, end due to the rred et the time,	ceuse(s) end m dete end plece,	enner es st end due to	teted. the cause(s	;)
complately filled	-	29b. Signeture and	title of certifier	2010	11	2.1	29	c. Licens	se number		29d. Dete signe			
		1 m	tul	. Man	ik.	Mus	-	03	32893	,	Febru	any	26,19	999
					-1 -1 -11 -11	-		-	- 0//			1	/ .	, , ,
		McClu Cl. Work M.D., D32893 February 26,1999 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Victor A. Wowk, M.D., 11119 Rockville Pike, Ste. #502, Rockville, Maryland 20852												



State of Maryland / Department of Health and Mental Hygiene

219-48-0165 sual Rasidence of Decedant Da. Stata 10b. County flaryland Prince Co De. Street and Number 4811 Somerset Ro 1. Meritel Stetus 1. Nevar Married 2 Merried 3 Widowed 4 Divorced 15. Decedant's Edi (Specify only highast grace Elamantary/Secondary (0-12) 7. Father's Neme (First, Middla, Last)	Lutz UI street and number) ad XM 2 F 7. Aga XM 2 F 8 George S ad 12. Was Decedant E Armed Forces? 1 Yes 2 X No Il Yas, Giva Year or Detes:	Rive	own or Location erdale 10f. 2 13. Was Dec If Yas, sp	der 1 Year s Deys	Riverda If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Aug. 19	Prince Year) , 1947 Og. Citizan of Wh	e George's 9. Birthplaca (State or Fore Country) Germany 10d. Inside City Lim Yes 2			
4811 Somerset Ro Social Security Number 219-48-0165 sual Rasidence of Decedant Da. Stata 10b. County Maryland Prince Co De. Street and Number 4811 Somerset Ro 1. Meritel Stetus 1 Nevar Married 2 Merried 3 Widowed 4 Divorced 15. Decedant's Edu (Specify only highast grace Elamantary/Secondary (0-12) 7. Father's Neme (First, Middla, Last) Walter Paul Co	ad A TANA 2 F TANA TANA TANA TANA TANA TANA TANA TA	(In yrs. last 51 10c. City, T Rive	birthday) Yrs. Months own or Location erdale 10f. Z 13. Was Dec If Yas, sp 1 Yes 6a. Decedent's Us	der 1 Year s Deys Zip Code 2073 Dedent of History Cubar	Riverda If Under 24 Hrs Hours Min. 7 spanic Origin? (S	March 4 Location of Death Le 8. Date of Birth (Month, Day Aug. 19	4c. County of Prince Year), 1947 Og. Citizan of Wh	1:15 AM (Death George's 9. Birthplaca (Stata or Fore Country) Germany 10d. Inside City Lim 1 Yes 2 1 hat Country? States American Indian,			
4811 Somerset Ro Social Security Number 219-48-0165 sual Rasidence of Decedant Da. Stata 10b. County Maryland Prince Co De. Street and Number 4811 Somerset Ro 1. Meritel Stetus 1 Nevar Married 2 Merried 3 Widowed 4 Divorced 15. Decedant's Edu (Specify only highast grace Elamantary/Secondary (0-12) 7. Father's Neme (First, Middla, Last) Walter Paul Co	George's George's ad 12. Was Decedant E Armed Forces? 1 Yes 20 No. If Yas, Giva Year or Detes: Jucation La complated) Collega (1-4or 5+	51 10c. City, T Rive	own or Location erdale 10f. 2 13. Was Dec If Yas, sp	Pip Code 2073 Redent of History Cubar	Riverda If Under 24 Hrs Hours Min. 7 spanic Origin? (S	8. Date of Birth (Month, Day Aug. 19	Prince (Year) 1947 Og. Citizan of Wh United S	e George's 9. Birthplaca (Stata or Fore Country) Germany 10d. Inside City Lim 1 Yes 2 1 hat Country? States American Indian,			
Social Security Number 219-48-0165 sual Rasidence of Decedant Da. Stata 10b. County flaryland Prince 0e. Street and Number 4811 Somerset Ro 1. Meritel Stetus 12 Nevar Married 15. Decedant's Edi (Specify only highast grace Elamantary/Secondary (0-12) 7. Father's Neme (First, Middla, Last) Walter Paul C	George S ad 12. Was Decedant E Armed Forces? 1 Yes 2 No 1 Yas, Giva Year or Detes: ucation fa complated) Collega (1-4or 5+	51 10c. City, T Rive	own or Location erdale 10f. 2 13. Was Dec If Yas, sp	Zip Code 2073 sedent of Historicity Cubar	If Under 24 Hrs Hours Min. 7 spanic Origin? (S	8. Date of Birth (Month, Day Aug. 19	year) , 1947 Og. Citizan of Wh	9. Birthplaca (State or Fore Country) Germany 10d. Inside City Lim 1 Yes 2 1 hat Country? States - American Indian,			
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21. Signature of Eunaral Sarvice Licensee 22. Nama and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910											
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	(Monny, Day	, our,	M								
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0	and mannar state	5G.		On Linears	number		Od Date sines	(Month Day Year)			
no. Signature and title of certifier			2	SG. LICONSO	numoer	2	ero. Date signed	(Month, Day, Tear)			
1 3666				D 28	656		March 5,	1999			
). Nama and address of person who c	omplated causa of da	ath (Itam 23	a) (Type, Print)								
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State of Maryland / Department of Health and Mental Hygiene

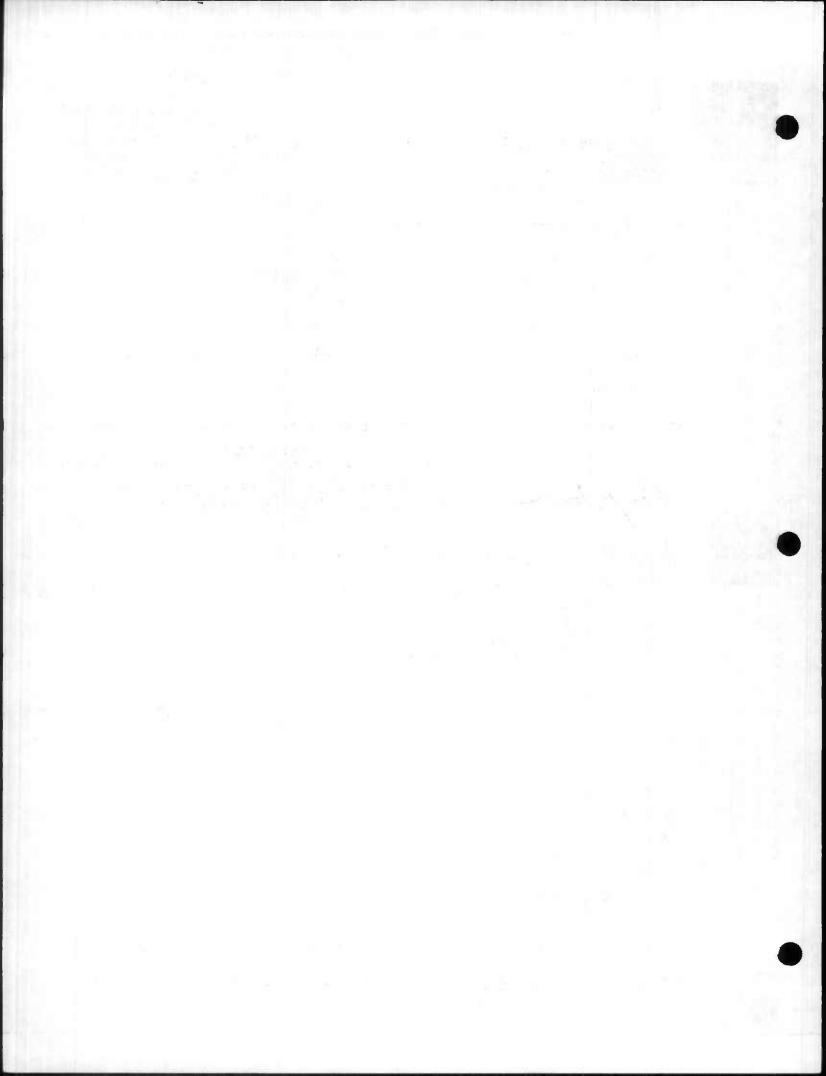
Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death Month Year **Physician** King Lee Chu February 27, 1999 1658 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1☑M 2□F Months Days Hours Yrs. Director 65 116-70-9401 China April 16, 1933 Usual Residence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland Rockville Montgomery 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ծ 13217 Superior Street Items 23a 20853 China Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or item pray injury or other traumetic event, the Mexical Examinan ones. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Worker Chinese Restaurant 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Kui Rang Chu Cai Mei Wu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 13217 Superior Street, Rockville, Maryland 20853 Shui Mei Chan/Wife 20b. Place of Disposition (Nama of cemetery, crematory or other place March 2, 1999 Montgomery Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300. West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part 1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest,

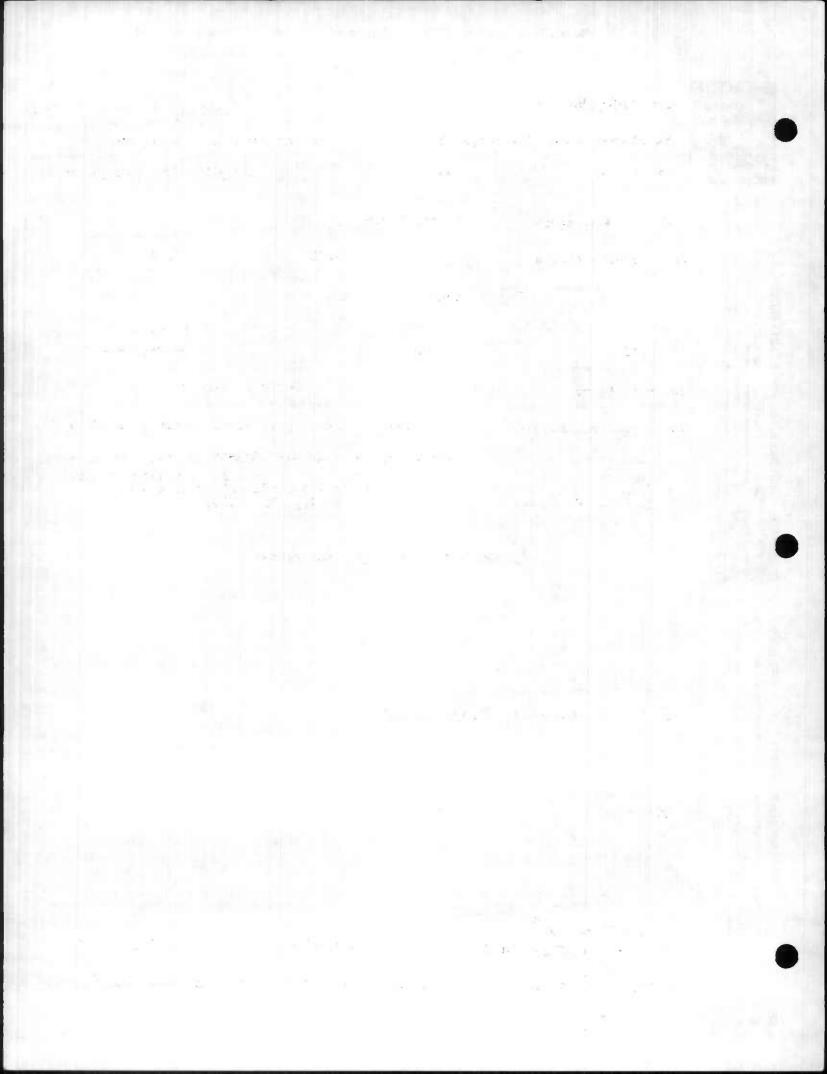
Approximate Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disaasa or condition resulting in death) /Medical weeks Examiner Examiner The lew requires that the death certificate be executed physicien and sthe burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or thiury that initiated events resulting in daath) Last P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of): for use es ed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No ate has been signed by pege 2 should be detec 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of ceusa of death? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 → npatient 2 □ ER/Outpatient 3 □ DOA 2 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Dascribe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No filled in by the f 3 Suicide 6 Could not ba datermined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours efter 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1x Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wid co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 320, Ruckville min DV. 9101 Medical center 31. Date fited (Month, Day, Year)
MAR 0 4 1999 32. Registrar's Signature State Registrar



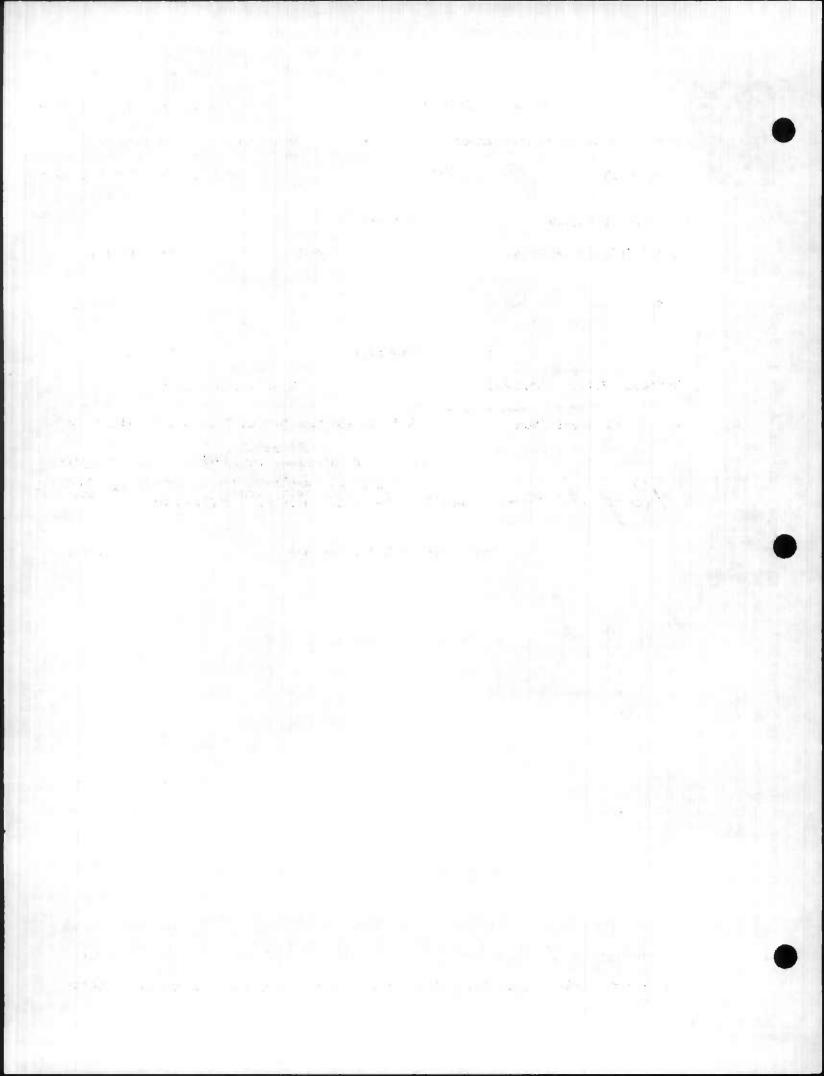
State of Maryland / Department of Health and Mental Hygiene

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xaminer	4.	la Facility Nema (4b. City, Town			4c. County	of Death		
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neral ector	5. Social Security Number 213-56-5387 G. Sex 1 M 2 F 7. Age (In yrs. last birthday) 44 Yrs. H Undar 1 Yes Months De									Min.	B. Date of Birt (Month, De uly 30	, Year) , 1954	9. Birthp Coun Mary	lace (Stete or Fo itry) 7 Land		
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any Injury or other trauma BDCs.	James F. Clark												. State. Zio	Code)		
	James F. Clark/Father 19b. Meiling Address (Street and Number or Rural Route Number, City or Town 12805 Littleton St., Silver Spring,															
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

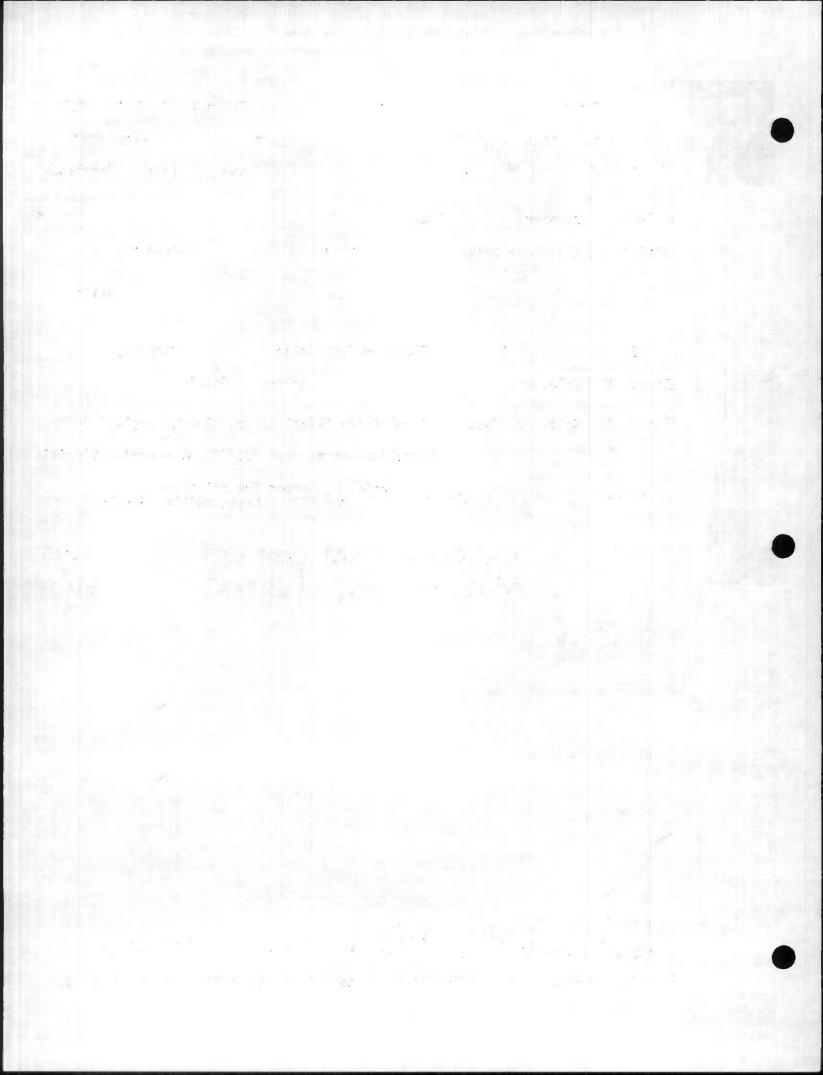
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician FEBRUARY** 28, 9:30 PM SUSAN COLE 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY 17705 QUEEN ELIZABETH DRIVE OLNEY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Min Maryland 220-58-7685 48 Yrs. Feb. 3, Director Usuat Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Montgomery Maryland Olney Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20832 17705 Queen Elizabeth Drive United States pemit. Peges 1 and 2 should be filed within 72 hours after deeth 1 Department of Health end Mental Hydene. Important: If item 27 is marked other than "natural", or items 231 and highery or other traumatic event, the Medical Examine must page. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0020 1 Tyes 2 XNo Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Technician Pharmacy 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) El wood В. Cole, Jr. Arlene Appel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cole, Jr./Father В. 17705 Queen Elizabeth Dr.,Olney, Maryland 20832 Elwood 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removal from State Metropolitan Crematory 3/1/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home wu Barche P. O. Box 5038, Laytonsville, Maryland 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** /Medicai Immediate Cause (Finet disease or condition resulting in death) Examiner Examiner ocarci vioma the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es e consequence of): 88 esn OF signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? peed hes 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Piece of Death (Check only one) examiner Other: 4 Nursing Home Statesidence 6 Other (Specify) 1 Yes ≥ No 9 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Naturel 5 Pending after death. Director: Aft 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Within 2 29b. Sign 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Peter Pushkas, M.D. 11510 Old Georgetown Road, Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 16 Rev 6/95

Registrar

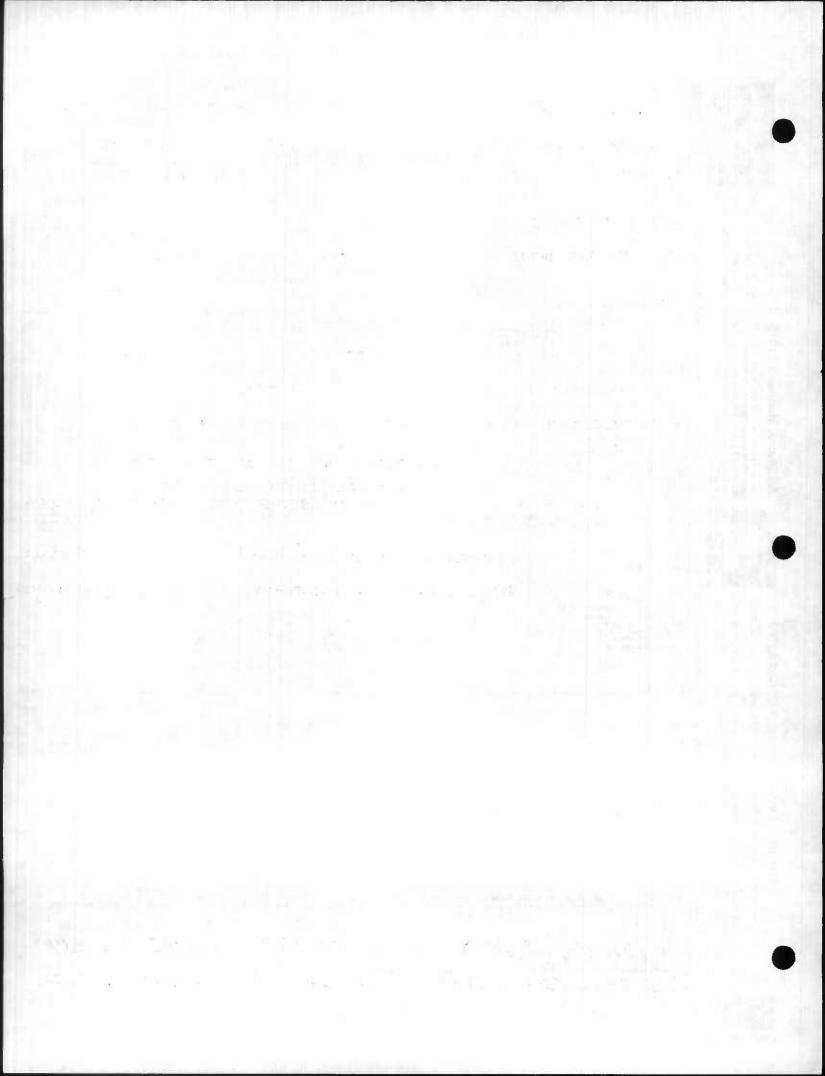
MAR 02



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) Month Dev **Physician** 1999 1, ANNE С. COOPER MARCH 9:30AM /Medical 4a Fecility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) **Funeral** Days 1□M 2図F Months Hours Min. Yrs. 91 217-32-1393 FEB. 18, 1908 PENNSYLVANIA Director Usual Rasidance of Decedant the Marylend 10e State 10b. Count 10c. City, Town or Location 10d. Insida City Limits r 28a-f show 1 Yes 2 No Directo MARYLAND MONTGOMERY ASHTON 10g. Citizan of Whet Country? 10e. Street and Number 10f. Zip Coda Pages 1 and 2 should be filed within 72 hours efter death with ment of Health and Mental Hygiane.
ant: (filem 27) is marked other than "natural;, or itema 23a or "ury or other than "natural; and "matter than the results event," its Medical Examine Trail Performance. 17717 TREE LAWN DRIVE 20861 UNITED STATES Funeral 14. Race - Amarican Indien, Black, White, etc. 12. Was Decedant Ever In U,S. Armed Forces? Wes Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yes 2 📉 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 Widowad 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) College (1-4or 5+) Elamentary/Secondary (0-12) ORGANIST CHURCH 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be THEODORE CONNER IDA NIXDORF 19b. Malling Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) MARGARET EISENHAUER/DAUGHTER 17717 TREE LAWN DRIVE ASHTON, MD 20861 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Page Department of Important: If any injury or pace. 4 ☐ Donation 5 ☐ Othar (Specify) LINCOLN CREMATORY 3/2/99 BRENTWOOD, MD 21. Signeture of Funeral Service Licensee 22. Nama and Addrass of Fecility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD20904 Approximeta Interval Batween Onsat and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** · Cerebrovascular Accident /Medical Immediata Causa (Final diseasa or condition rasulting in daath) Examiner Myocardial Infanctio Examiner tha death certificata be axecuted physician and s tha burial-trans Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or es a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es e consequence of): 98 950 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware eutopsy findings aveilable prior to completion of cause of daath? Completed 24a. Was an autopsy page 2 has 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa rafarrad to medicel axeminar? Be 28. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 1 Yas 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding after death. 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rurat Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida filled in 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Cartifiar To the Hosp within 24 hor To the Fune completely fi edical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number D37930 MARCH 1, 1999 20 30, Nama and addrassy of person who complated causa of daath (Item 23a) (Type Prigt) .

ROBERTH. KNUTZEN 1810 Prince Philip Dr. SEE 312 OLNEY, MD. 20832 31. Deta filed (Month, Day, Year) 32. Registrar's Signatura State MAR 03 1999 Registrar



10d. inside City Limits

1 ☐ Yes 2 ☑ No

MONTGOMERY

Funeral Director

28a-f show Directo Funeral þ

with the Marylend in than "natural", or items 23s or 28s-1 show the Medical Example of must be notified at permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Medical Example page.

Completed

2

Physician/Medical Examiner

2

Completed

Be

2

Certification:

edical

Saltimore, Maryland 21215-0020

Physician /Medical Examine

physician and the burial-transit The lew requires that the deeth certificate be executed ettending p signed by the e should s certificate has t director, page 2 s or Attending Physician: director, this After deeth. after deeth Director: A 1 in by the f To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b

Division of Vital Records, P.O. Box 68760,

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 28, 1999 FEBRUARY VIOLA CRAVEN 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death FRIENDS NURSING HOME SANDY SPRING | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Dey, Year) | No.V., 1909 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthpiece (Stete or Foraign 1□ M 2□ F Illinois 338-05-2818 89 Yrs Usuei Residence of Dacedant 10e State 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2503 Glenallan Avenue, #3 20906 United States 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ill Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican indien, Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Nevar Married 2 Married White 1□ Yes 2⊠ No 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Office Worker Telephone Company 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Surnama) Anton Egnot Genevieve Ziogas 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John E. Craven / Son 2503 Glenallan Ave., #3, Silver Spring, Md. 20906 20b. Pieca of Disposition (Nema of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Data 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Metropolitan Crematory 3/1/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura of Funerei Service Licensee 22. Nama and Address of Fecility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiretory errest, shock, or heart feilure. List only one ceuse on each lina. immediate Cause (Finel disease or condition resulting in deeth) . PNEUMUNIA Due to (or es e consequence of): SPIRATION

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasuiting in deeth) Lest

Due to (or as a consequence of)

Due to (or as a consequance of):

Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

PARKINSON'S DISEASE

23b. Did tobacco usa contribute to the cause of death?

1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en eutopsy performed?

26. Piece of Deeth (Check only one)

24b. Were eutopsy lindings available prior to completion of cause of deeth?

Approximate intervel Between Onset end Deeth

ONE WEEK

ONEWEEK

1 Yes 20 No

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical 1 ☐ Yes 🔊 No

5 Pending investigation

28e. Dete of injury (Month, Day Year) 6 Could not be determined

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Pieca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. injury at Work?

1 □ Yes 2 □ No

Other: Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28l. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

27. Menner of Death

1/5 Neturei

2 Accident

3 Suicida

4 Homicide

妆 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner stated.

29b. Signeture and title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

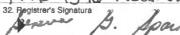
D23124

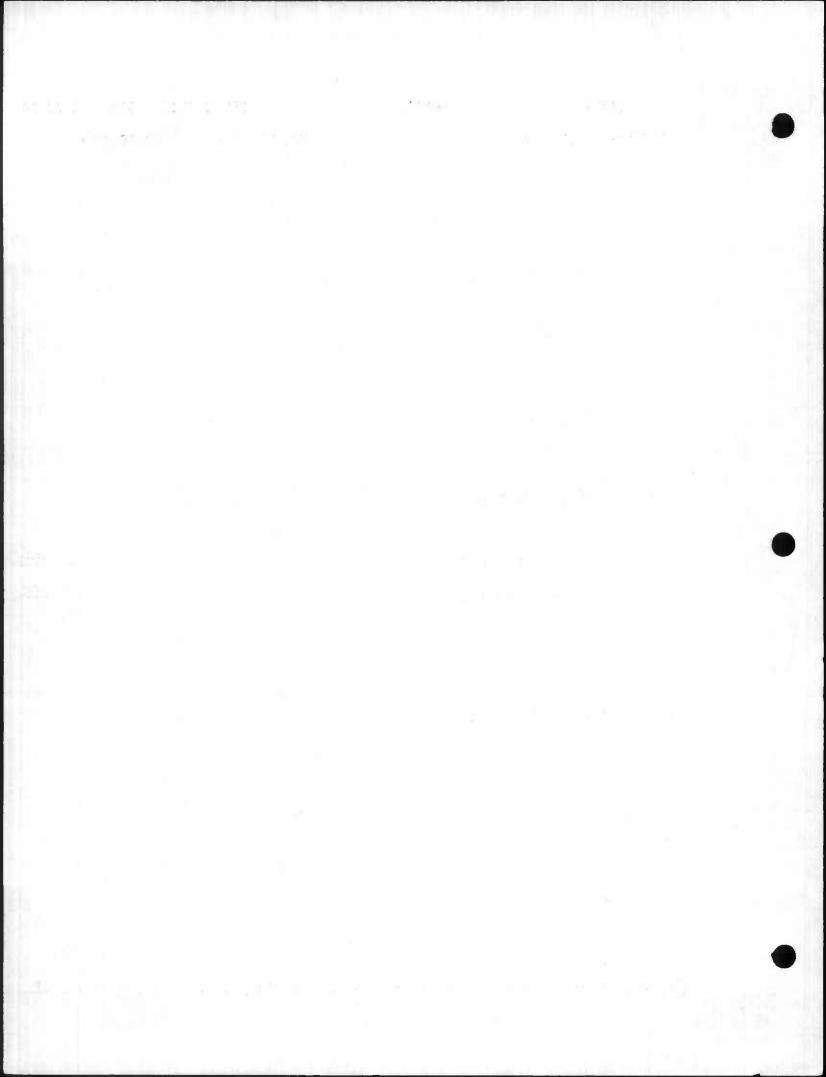
March 1, 1999

DENNIS M. HANNON, MO 1396 PICCARD DRIVE, ROCKVILLE, MARYLAND 31. Date liled (Month, Dey, Year)

State Registrar

MAR 02 1999





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month **Physician** Chester H. Czerw February 24, 1999 12:45 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 3125 Jennings Road Kensington Montgomery If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 □ F Yrs. 207-05-1409 Director July 21, 1917 Pennsylvania Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 TNNo Director MD Montgomery Kensington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3125 Jennings Road 20895 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Neme : 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, 11 Meritel Status Black, White, etc. Yes 2 No
If Yes, Give
Year or Detes: 1941-45 filed within 72 hours after 1 Never Merried 2 Merried natural, or Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White P 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heelth and Mental Hygiens Important: If frem 27 is marked other than any injury or other traumatic event, traumatic event, traumatic event, traumatic event, traumatic 12 Cartographer Defense Mapping Agency 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Julia Zombach John Czerw 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 10711 St. Margaret's Way, Silver Spring, MD Barbara E. Czerw (daughter) 20e. Method of Disposition 20b. Plece of Disposition (Neme of Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 2/27/99 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signature of Funerel Service Licensee Home, Inc. Silver Spring, MD 20901 23e. Part f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner pteriol that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es a consequenca of): P.0. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown signed I Division of Vital Records. þ 24b. Were eutopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manger of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 (Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, Ierm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifie 29c. License number

140)

State Registrar

MAR 0 1 1999

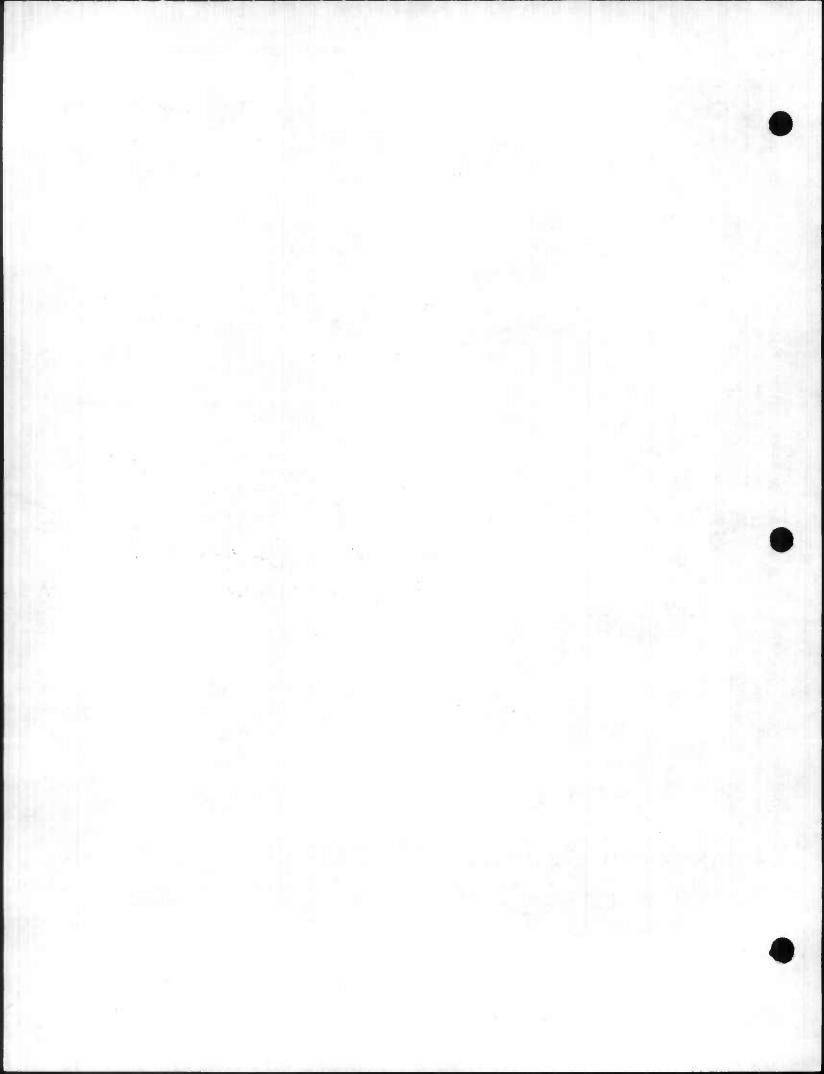
31. Dete liled (Month, Day, Year)

9 32. Registrar's Signeture

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

61

Sparks



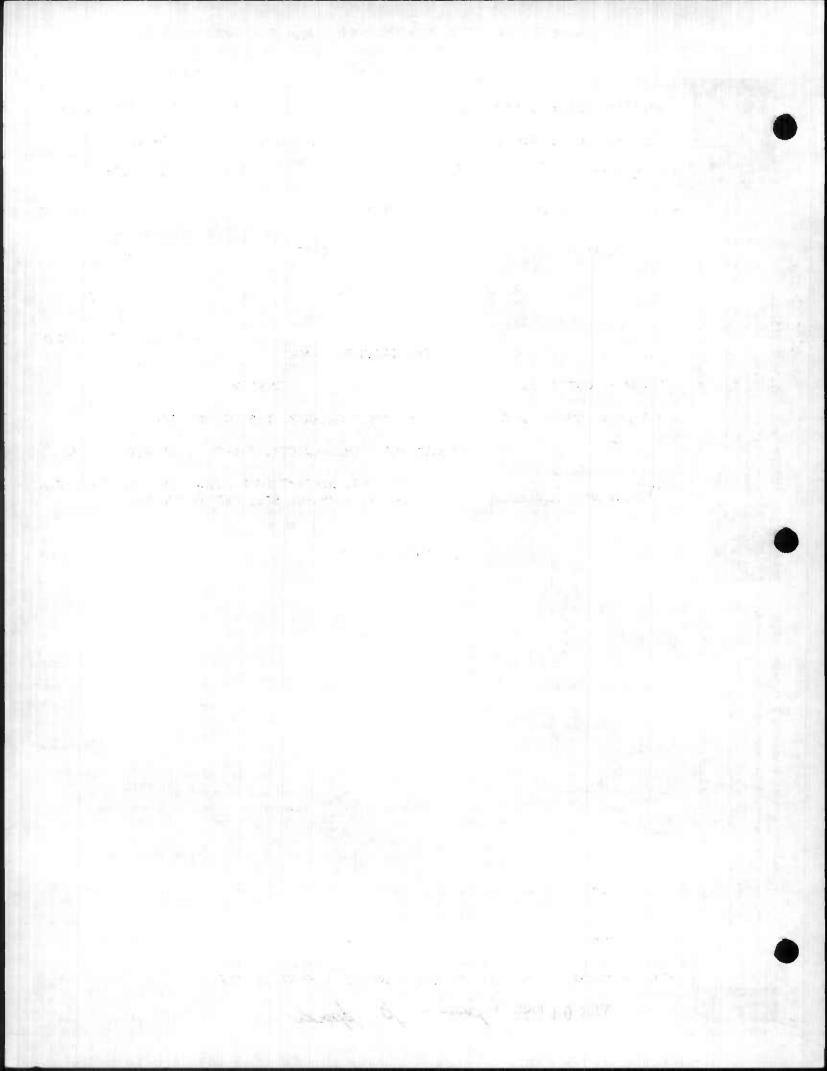
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death Day Month Yaar **Physician** WILLIAM HENRY COYNE, JR. 1999 2205 March /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** The Memorial Hospital Talbot Easton 8. Date of Birth (Month, Day, Year) If Undar 1 Year If Under 24 Hrs 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours **X**M 2□ F 72 Director OCT. 17,1926 MASS. 028-12-5754 Usual Rasidance of Dacedan the Meryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Madical Examinar must be notified at MD TALBOT EASTON 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? With 9781 OCEAN GATEWAY 21601 USA Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Reca - American Indian, Bleck, Whita, atc. 12. Was Decedant Evar in U,S. Armad Forcas? 11. Marital Status hours efter 1 TYes 2 No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married 0 1 Yas 2 No Specify: Specify: à WHITE 3 Widowed 4 Divorced "natural", Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry al Hygiene. FOOD PACKING INDUSTRY Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 MAINTENANCE MANAGER 18. Mother's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Pages 1 end 2 should be "UNKNOWN" 2 WILLIAM H. COYNE, SR. and si 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2 Department of Health a Important: If item 27 is any injury or other trav MARGARET E. COYNE/ WIFE 9781 OCEAN GATEWAY, EASTON, MD 21601 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 【Cramation 3 ☐ Ramoval from Stata CHESAPEAKE CREMATION CTR. 3-4-99 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Ostrowsk. Joseph M. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onset and Death **Physician** /Medical Immediata Causa (Final Emphysema disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner that the death certificete be executed Sequentially list conditions, if any, laading to immadiala ceusa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last the burief-tran Dua to (or es e consequence of): pue P.O. Box 68760, ettending physician for use es the burie Physician/Medical Dua to (or as a consequence of) ate has been signed by the pege 2 should be deteched Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings eveilabla prior to complation of ceusa of death? 24a. Was an autopsy Completed 1 Yes 2 TNo 1 Yas 2 No Division of Vital director, Be 25. Was cesa rafarrad to medicel 26. Placa of Daath (Check only ona) axaminari Othar: 4 → Mursing Homa 5 □ Residence 6 □ Othar (Specify) 2 1 Yas 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA this s funerai 27. Mannar of Daath 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: After 1 Watural 5 Panding Injury s effer des. 1 Yes 2 No 2 Accidant 3 Suicida 6 Could not be datarmined 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida 5 Hospital 24 hours e Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifian Medical To the within 2 29c. Licanse number 29d. Data signed (Month, Dav. Year) 29b. Signalura and titla of certifiar MI 199 30. Nama and addrass of parson who complated ceusa of daath (Itam 23a) (Type, Print)

State Registrar 31. Data filed (Month, Day, Year) MAR 04 1999

PETER WHITESELL, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601 32. Registrar's Signatura

Spark



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Death February 25, 1999 **Physician** 1643 Helen Faye Cummins /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Havre de Grace Harford Harford Memorial Hospital 8. Dete of Birth (Month, Pay, Year) 34 If Under 1 Year if Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birtholace (State or Foreign 6. Sex **Funeral** Months Davs 1 M 2OXF Virginia 216-30-7983 64 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Haalth and Mantel Hygiane. Important: If them 27 is marked other than "nature!, or items 23s or 28s-f show highly or other traumatic event, the Maryland Examiner must be not the page. 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 TYes 2 □ No Directo Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 111 West Inca Street Funeral Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Maritai Status Black. White, etc. Yes 25 No 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 11 Homemaker In home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Mae Salvers Thomas Edward Brewer 2 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 West Inca Street, Aberdeen, Maryland Stephen A. Cummins (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gardens 3/2/99 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 a 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner end i-transit that the death certificeta be executed Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence of): physician er P.O. Box 68760, Physician/Medical Due to (or as a consequence of) for use es 80 signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ The law requires 24b. Were autopsy findings eveilable prior to completton of ceuse of death? been si 24a. Wes an autopsy Completed is certificata has director, pege 2 1 Yes 2CY No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after daath. Funeral Director: After this certifici Be 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident rector: / 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours aft To the Funeral Di completaly filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and little of certifier D. Name and address of parson who completed ceuse of death (Item 23a) (Type, Print) 0 219 W. BELYCU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

State Registrar

MAR 0 3 1999

Because A. Sparke

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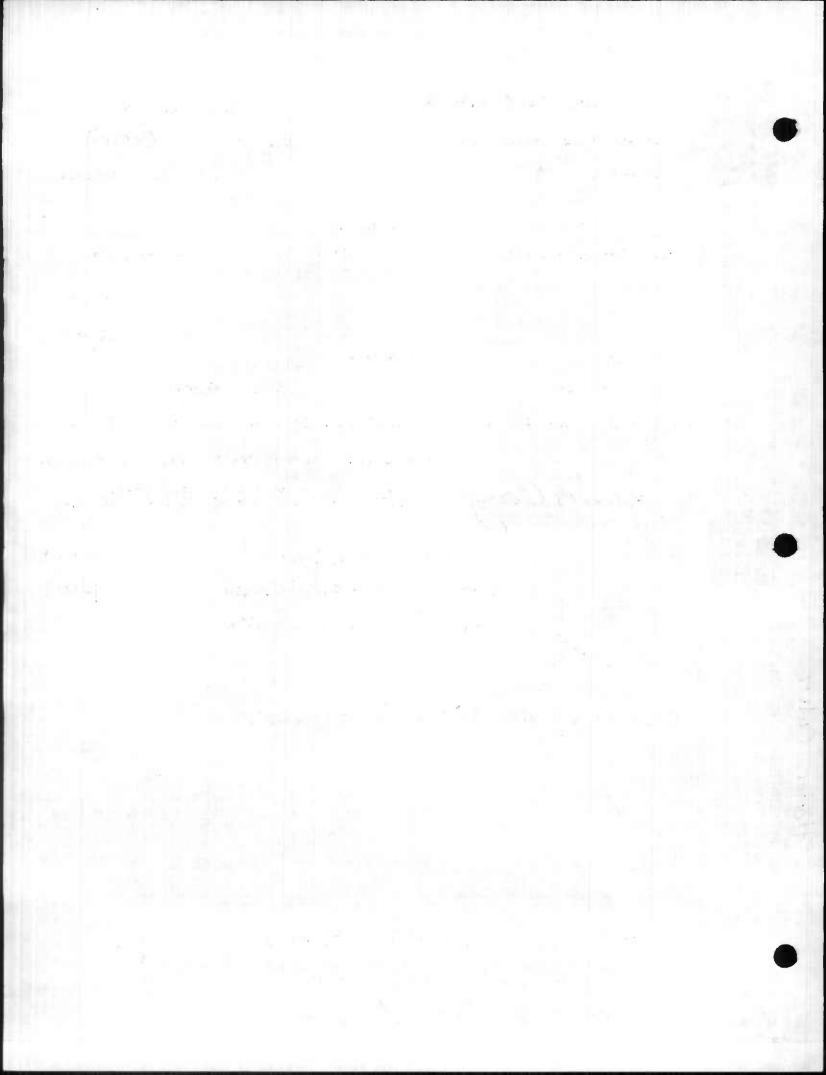
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Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Homer L. CulvER Month Year **Physician** Feb. 28 1999 2:10 PM · /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Carroll Pleasant View Nursing Home Mt. Airy If Under 1 Year | If Under 24 Hrs. | 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Date of Birth (Month, Day, Year) **Funeral** 1₩ M 2□F Months Days Hours Min 96 Yrs. Director 577-60-7043 Dec. 4, 1902 Kentucky Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be noutried as 1 ☐ Yes 2 No Directo Maryland Frederick Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9531 Clemsonville Road 21791 United States death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black White etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: If item 27 ie merked other than "natural", or item any Injury or other treument. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White Specify: þ 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Walter Reed Medical Elementary/Secondary (0-12) College (1-4or 5+) Center 10th grade Machinist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Kellen William Culver Mattie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kim Gouge Granddaughter 9531 Clemsonville Road Union Bridge, MD Baltimore. 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Calvary Baptist Ch. Cem. 3/4/99 4 ☐ Donation 5 ☐ Other (Specify) Mt. Airy, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Burrier-Queen Funeral Directors, P.A. ama B dreus 1212 W. Old Liberty Road Winfield, MD 21784 ter the disease, or complications that we d the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, heart feilure. List only one ceuse of each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Fine MINUTES CARDIAC Arry th MIN diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Coronary Athensclendes physicien end the burief-tren Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of e roscle roses Division of Vital Records, P.O. Box 68760, Genera Physician/Medicai Due to (or as a consequence of) Se esu. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown cerebral vascular accident, Hypertensor 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy Completed performed' page 2 s 1 Yes 2 No 1□ Yes 2□No funerel director. 25. Was cese referred to medicel examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Injury 1 Natural 5 Pending 1 Tes 2 No 24 hours efter deeth. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò Hospital 29e. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. (Check only one) 29c. License number 86 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier Kordn 3 99 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 4801 Dorsey Hall Drive MI CORDON Columbia, MD 21042 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 1999 Registrar

Homer



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JOSEPH ELWOOD CROFT 1999 MARCH 9:10 AM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 117 DUNROVIN AVE. WESTMINSTER CARROLL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Days Hours 17⁄2 M 2□ F Yrs. 78 212-16-8243 1/27/1921 MARYLAND Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No MD. CARROLL WESTMINSTER 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 117 DUNROVIN AVE. 21157 USA. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 17 Yes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Merried 2 ☑ Married 1 Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ENGINEER GOVERNMENT 8 18. Mother's Neme (First, Middle, Malden Sumame) 17. Father's Neme (First, Middle, Last) CHARLES C. CROFT, BESSIE FLICKINGER SR. 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN N. CROFT - WIFE 117 DUNROVIN AVE., WESTMINSTER, MD.21157 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1X Buriai 2 Cremation 3 Removal from State ST. MARY'S CEMETERY 3/4/99 SILVER RUN, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 med the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth COLON Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1□ Yes 2 LING 1 Yes 2 No 28. Place of Death (Check only one)

Physician /Medical Examiner

Physician

· /Medical

Examiner

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item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at

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Saltimore, Maryland 21215-0020

Box 68760.

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Division of Vital Records,

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to madical examiner? Hospital Other: 4 Nursing Home 5 Desidence 8 Other (Specify) 1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h. Time of 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Phyalcfan: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) one)

29b. Signatur

29d. Date signed (Month, Day, Year)

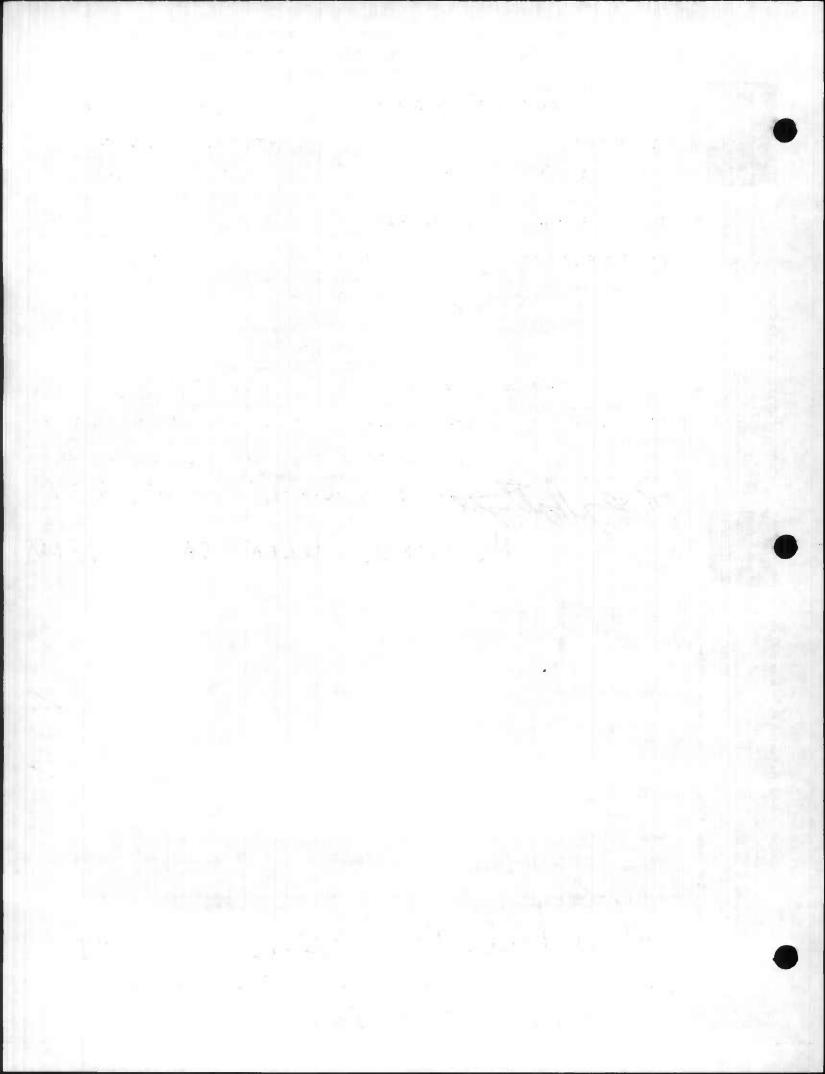
Westminster mo 21157

completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician Month - MORE MARCH 1999 0758 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WICOMICO Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. lest birthday) If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 9. Birthplece (State or Foreign Country) Deys Hours 1**X** M 2□ F 218-05-8805 84 Yrs. MD 10a State 10b. County : Oity, Town or Location 10d. Inside City Limits MDDirector 1 No 2 No 11ncess 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 21853 May ames Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 \$\$\text{Tyes} 2 □ No If Yes, Give Yeer or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - American Indian Bleck, White, atc. 11. Marital Status 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 🕱 No Specify: þ Specify. 3 XWidowed 4 ☐ Divorced lack Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Scit - Inployed 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) - Inployed 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Nema (First, Middle, Last, Be ARL Midia Jertrude -00KS 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 29989 St. James Way t Son larence 01bin ND 21853 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cuemetory or other plece) 20c Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 Removel from State Cemerky 3-13-99 Hope 4 ☐ Donetion 5 ☐ Other (Specify) MT. incoss y 21. Signature of Funerel Sarvice License Name and Address of Facility Funcial orthony and. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Intervel Between Onsat end Deeth MD 21853 Immediate Cause (Final 24 MRS AGULE disaasa or condition resulting in deeth) Due to (or es e consequence of): Pueumoulg 24 4KS Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? RENAL FAILURE 1 Yes 2 No 3 □ Probably 4 ☑ Unknown þ Completed PROSTALT CALCEL. 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of causa of deeth? NIL DEMEN4. 1 Yas 2 No 1 Yes 2 No Be 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) axaminer? Hospital: 1.2 Inpatient 2 ER/Outpetient 3 DOA Certification: To 1□ Yes 2□No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1. Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 4 Homicide Medical

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Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MAHESY MOONDRA MD 106 MILEORD St 504B SAlivBURY MD 2/804.

State Registrar

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31. Dete filed (Month, Dey, Year) MAR - 8

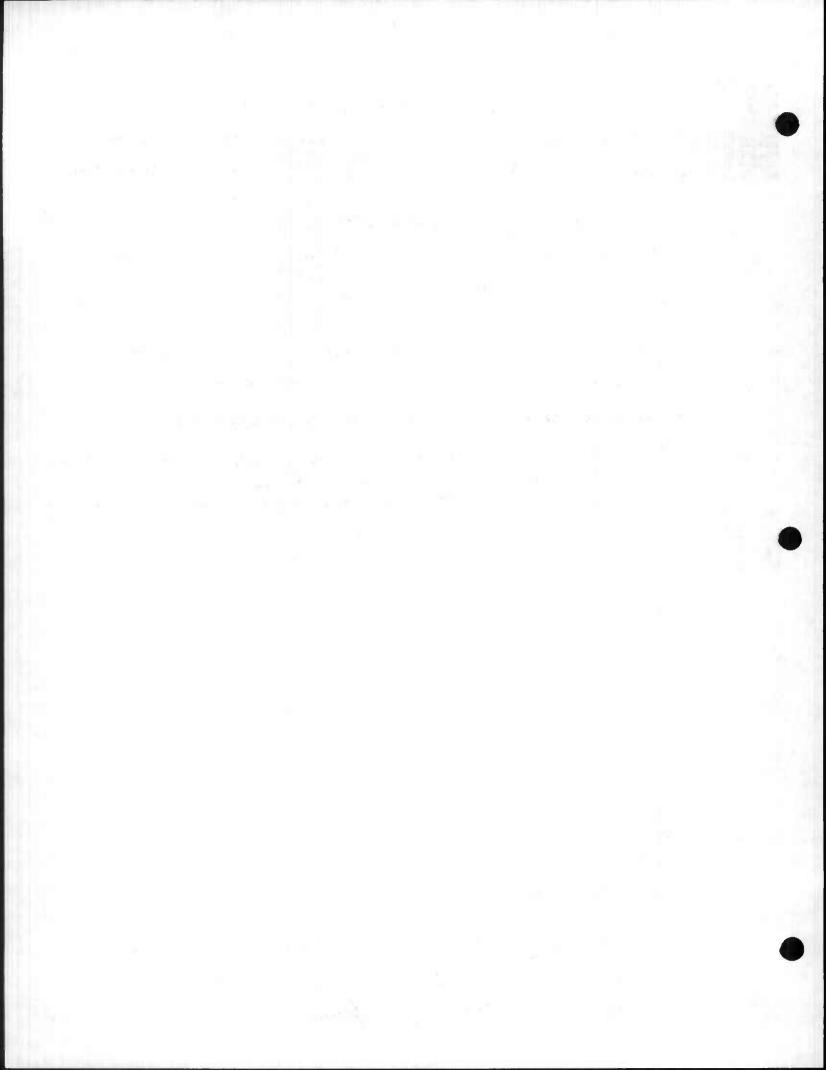
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Marie Dawson Clark March 0.1 1999 0405 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth The Kent & Queen Anne's Hospital Inc. Chestertown Kent 7. Age (In yrs. lest birthday) If Under 1 Year Months Deys If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 1 □ M 2 ▼ F Hours 216-18-8326 redryley 9, 1924 Usual Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits ANNES MD QUEEN CHESTERTOWN 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21620 204 KIVERVIEW U.S.A 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Specify: WHITE If Yes, Give Yeer or Dates: Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education fy only highest grade completed) 16b. Kind of Business/Industry Elementery/Şecondary (0-12) College (1-4or 5+) HOMEMAKER HOMEMAKER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) DAWSON EARL WHITBY ELIZABETH 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2/120 19e. Informent's Name/Relationship (Type, Print) W. WHALLOD CLARK ILL 210 MANGE AVENUE CHESTERTOWN, MD 20c. Location - City or Town, Stete. 20e. Method of Disposition 20b. Plece of Disposition (Neme of Dete cemetery, cremetory or other place) 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State MARCH 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND VETERAN LEMERCY 4, 1989 21. Signeture of Furteral Service Licensee 22. Name and Address of Facility MARVIN V. WILLIAMS FUNCHE SERVICE 21620 205 GREEN HERON WAY CHESTERFOUND MO 23a. Pert1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth immediate Ceuse (Final diseese or condition resulting in death) 200515 Due to (or es e consequence of): umosi Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting In death) Lest Due to (or es e consequence of): ronic Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evelleble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 26. Piace of Deeth (Check only one)

Physician /Medical Examiner

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After

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of or Attend efter death Director:

To the Hospital within 24 hours of To the Funeral Completely filled Hospital

Physician

/Medical

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Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mertal thygiene. Important: If item 27 is marked other than "natural", or ite any finury or other traumatic event, The Meorical Exp. since any finury or other traumatic event, The Meorical Exp. since

Baltimore, Maryland 21215-0020

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Physician/Medical Examiner for use es the burial-tran be deteched þ pege 2 should Completed Be 20 funeral Certification: filled in by the

The lew requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital Attending Physician: Pert ii. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 25. Wes case referred to medical examiner? Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Dete of injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner steted. 29a. Certifier (Check only one)

State Registrar

Medical

Nayne 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

30. Neme end eddress of person who completed

MAR

32. Registrer's Signeture

of deeth (item 23e) (Type, Print)

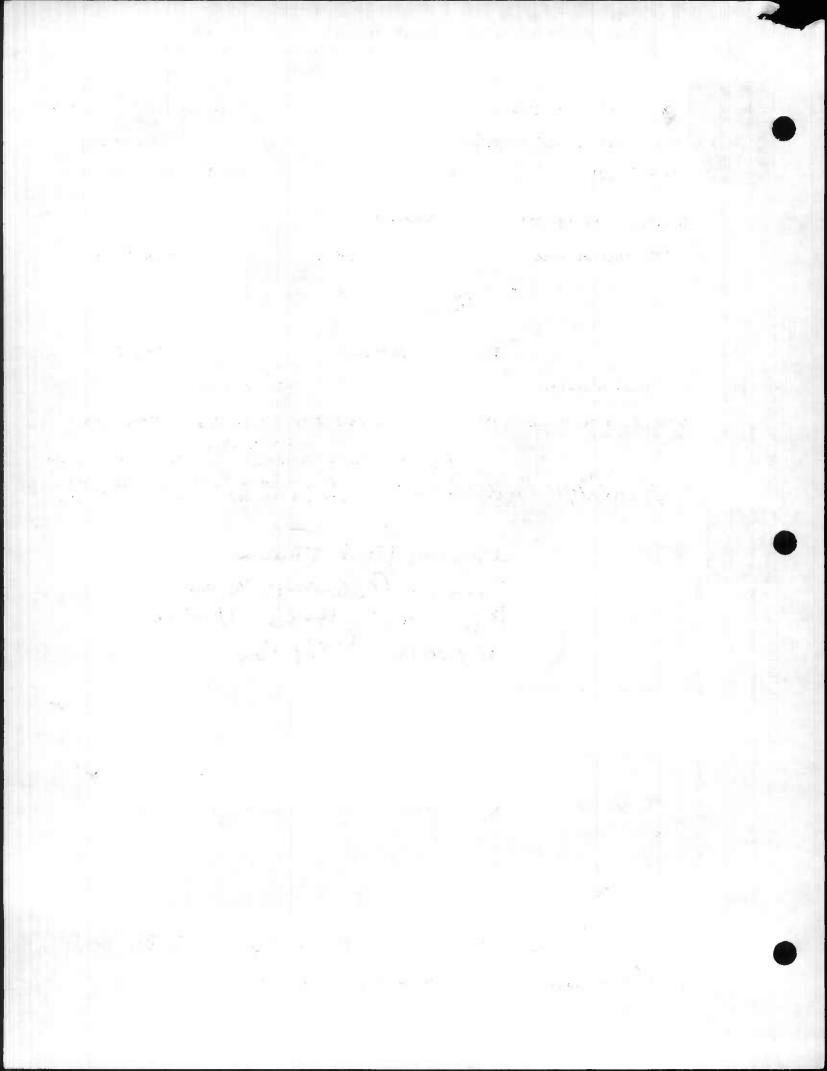
29c. License number

29d. Dete signed (Month, Dey, Year)

State of Maryland / Department of Health and Mental Hygiene

			State of Mary		Certifica	e of	Death	Re	g. No.	U	3436)
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permit. Pegas 1 a Department of Hes Important: If Item any Injury or othe ans.		21. Signature of Funeral Service Licenses	nn D M	00831	22. Name e	nd Addr	ess of Facility Imphrey Fune:	ral Home /R	atheeda_(hour	Chase	Tnc
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Tima ol Death 2. Data of Death **Physician** Berthelene M. 2, 1999 2:27 PM Davis March /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's 2224 Charleston Place Hyattsville Il Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug. 5, 19 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖾 F Yrs. 579-32-8780 1924 74 Director Iowa Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Director MD Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 2224 Charleston Place 20783 USA items 23s eral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian. Fun Black, Whita, atc. permit. Peges 1 end 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: If Item 27 is marked other then "natural", or ites eny injury or other treumatic event, the Medical Examinations. 1 Yas 2 No II Yas, Giva Yaar or Datas: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 Yas 2 No Specify: à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be William C. Meyer Jessie Buthman 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mark F. Davis/Son 325 Pecan Court, Millersville, MD 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Burlal 2 Cramation 3 Ramoval Irom State Maryland Veteran's Cemet. 3/8/99 Cheltenham, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Francis J. Colling Funeral Home, Inc. 500 University Blvd., West aral Sarbice Licensaa 20901 Silver Spring, MD Approximata Interval Batween Onset and Death 23a. Part1. Enfor the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Due to (or as a consequence of): Examiner Examiner physician and s the bunal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequance of): Box 68760. Physician/Medical Dua to (or as a consequence of) 88 attending p P.O. ed by the a Part It. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should be det Records, à 24b. Wara autopsy lindings available prior to Completed 24a. Was an autopsy completion of causa of death? 1 Yas Q No certificate Division of Vital or Attending Physician: director. Be 25. Was casa ratarred to medical axaminar? 26. Placa of Death (Check only ona) 1 Yas 2/7 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28d. Dascribe how injury occurred 28a. Data ol Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 10 Natural 5 Panding invastigation death. 1 Yas 2 No To the Hospital or Attendition within 24 hours after death.
To the Funerel Director: A completely filled in by the fi 2 Accidant 6 Could not be detarmined 3 Suicida Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homiclda Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a Certifier 29b. Signature and title of Certifle 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and addrass of pe ion who complated causa ol death (Item 23a) (Type, Print) 701 GUINGSTU

Registrar DHMH 16 Rev 6/95

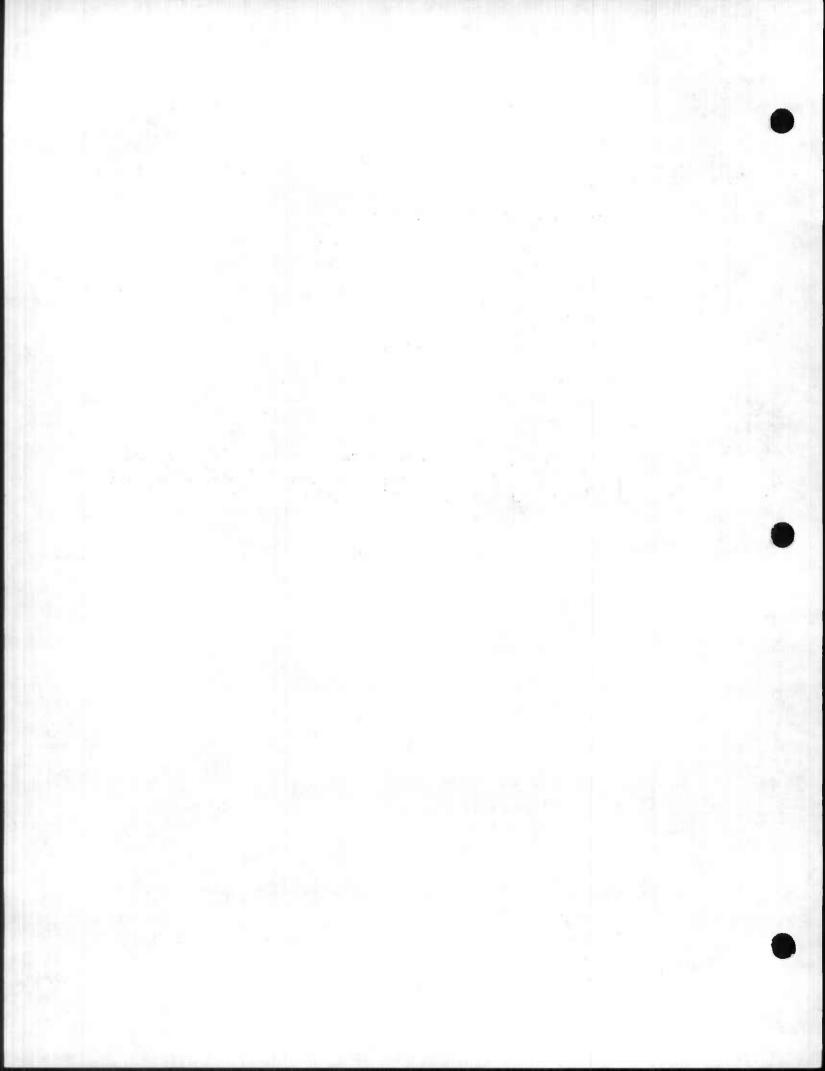
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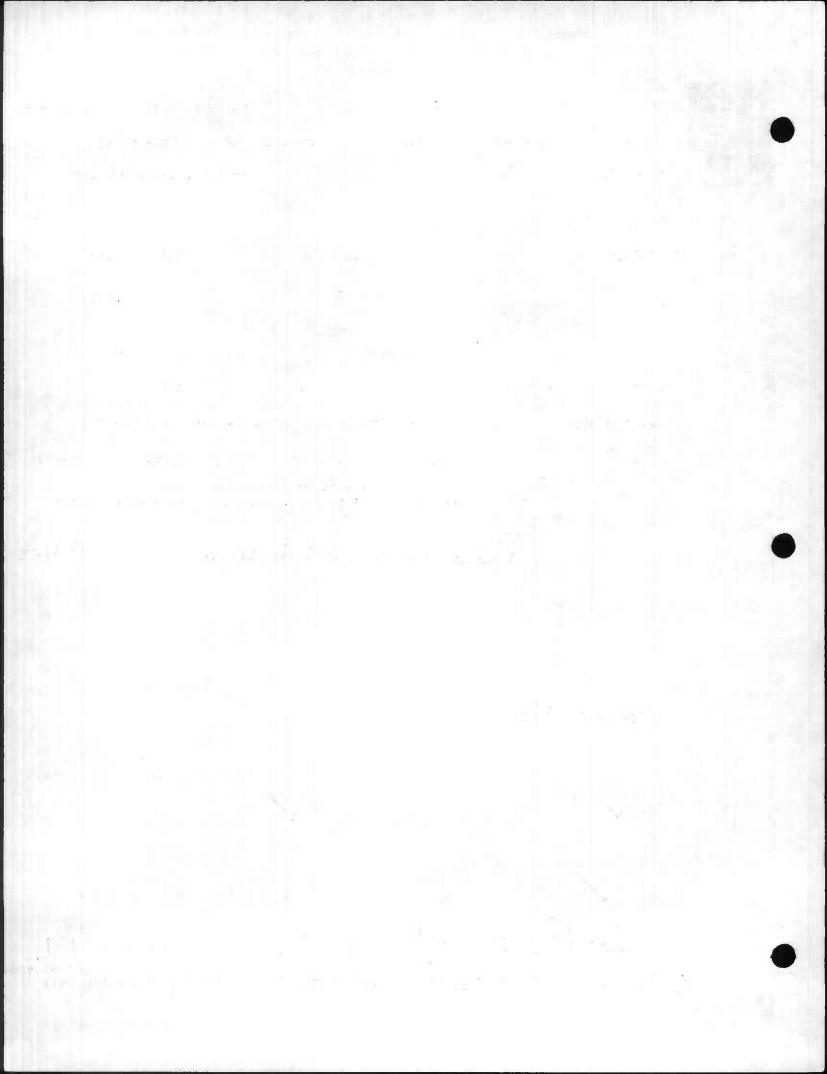
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

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1	Physici /Medi		Mary A. Dugan						Feb	2 6	99	9:50 pm
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Baltimore,			4 ☐ Donation 5 ☐ Other (Spaci 21. Signature-of Funaral Servica Lice		ALL					Arling		
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1	Physician /Medical Examiner	Je.	Immediate Cause (Final disease or condition resulting In death)	e. Eno	Due to (d	tag or es allons	e Chron;	ic Obs	tructive	Pulmo		Interval Between Onset and Death Year Lisease
_	ete be executed hysician end the buriel-transit	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (d	or as e cons	sequence of):					
ox 68760,		edical	Cause (Disease or injury that initiated events resulting in deeth) Lest	d	Dua to (c	or as a cons	equenca of):					
P.O. Box	thet the deeth ed by the atte datached for	Sicia	Pert II. Other significant conditions of	contributing to death be	ut not res	sultina In the	underlylng cause gi	ven in Pert I.	23b. Dld	tobacco usa c	ontribute to	the cause of death?
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		piet							- Pont	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	com	npletion of cause leath?
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™ Vital		BeC	25. Wes case referred to medical					28. Plece of D	eeth (Check only	one)		
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9 6	ding Phys h. After this funeral di	Ë.	27. Menner of Death 1 ☑ Natural 5 ☐ Pending	28a. Dete of Inju (Month, De	ry Year)	28b. Time Injury		ry at rk?	28d. Describe	how injury occu	irred	
Name	ttandir deeth. :tor: Af / the fu	Satio	2 ☐ Accident investigation	n				Yes 2□No				
Name; Division of	tal or Att	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injubulding, etc.	ury - At h	oma, ferm, : fy)	street, fectory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural	Route Number,
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	10		30. Negre and address of person who	completed cause of d	M J eeth (iten	n 23 <i>e</i>) (Typ	e Print)	105/		March		
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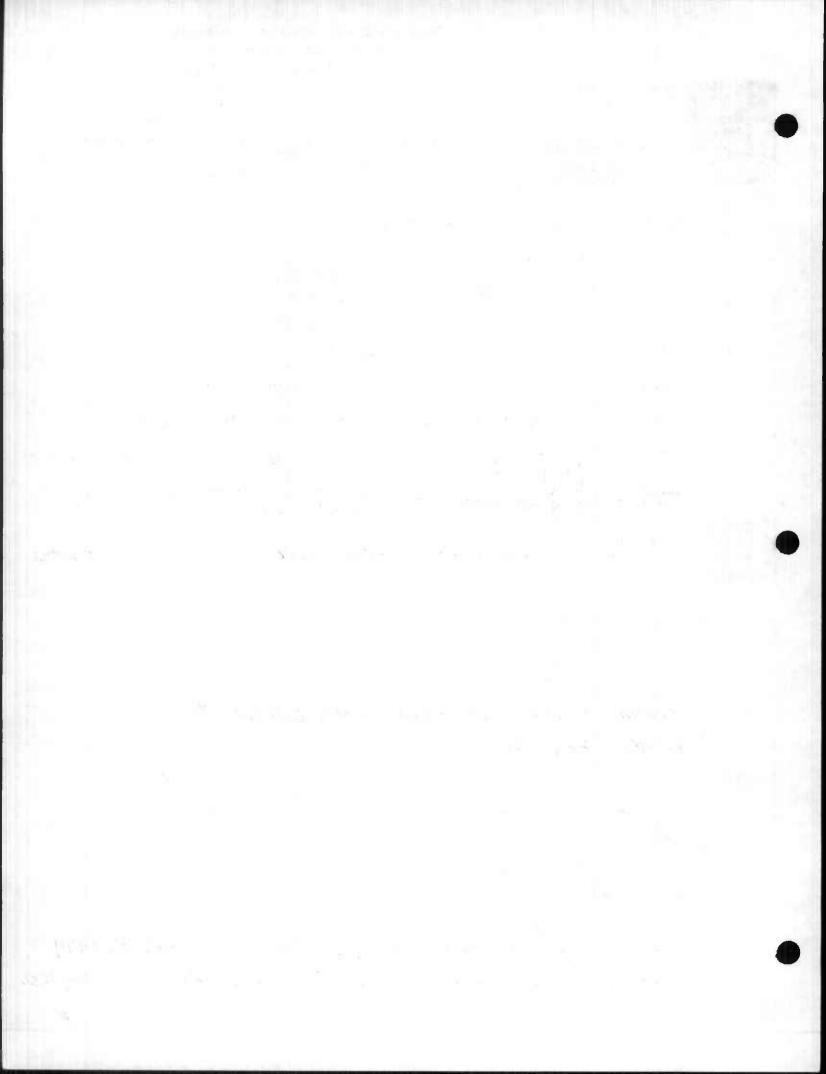
DHMH 16 Ray 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene

				Ce	ertificate of	f Death	R	eg. No.	U	3 4 4 f	U
		1. Decedent's Neme (First, Middle, La	st)				2. Dete of Deer Month	-	Vees	3. Time of	Deeth
Physic /Med		SYLVIA DU	ISKES				March		Yeer 999	4:50	P. M.
Exam		4e. Fecility Name (If not institution, given	e street and number)			4b. City, Town, or I	ocation of Deeth	4c. County	of Deeth		
		Shady Grove A	dventist Ho	spita	1	Rockvi	lle	Мо	ntgo	mery	
Funera	1	Social Security Number 6. S	Пм оПг	rs. last birthday	Months Dey		8. Dete of Birth (Month, Day,	Year)	9. Birthpl	lece (State or	r Foreign
Directo	e.		M 2TF	85 Yrs.			August	20, 191	3 Ne	w Yor	
and *		Usuel Residence of Decedent 10e. Stete 10b. County	10c.	City, Town or L	ocation				10	0d. Inside Cit	ty Limits
f sho	ō	V 1 1 V								1 ☐ Yes	
the the l	Tec.	Maryland Montgon 10e. Street end Number	nery	Rockvil	10f. Zip Code		1	0g. Citizen of \	What Coun		_XX
5-0020 72 hours efter death with the Maryland naturel', or tems 23e or 28a-f show of the startings must be notified at	Funeral Director	1801 E. Jefferson	Stroot		20852			U. S.		uy.	
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offer of the control		1 Never Married 2 Merried	Armed Forces? 1 ☐ Yes 双翼No				o Ricen, etc.)	Bied	ck, White, e	etc.	
alf, o	b	₩ Widowed 4 Divorcad	1 ☐ Yes XX No If Yes, GiveX X Year or Dates:		1 ☐ Yes XX No	o Specify:		Specify	whi	lte	
d within 72 hours of giana. In then "natural", or	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usuel Occu	upation	kina	16b. Kind of B			
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permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other		21. Signature of Funeral Service Lice	7 / /		2. Name end Add	,	Wanning 1	1 01	1 - 7		
)		Location !	June		170 Rock	<u>-G</u> oldberg ville Pik	Memoria.	ille M	15, I	.nc.	
		234. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceused the de one ceuse on each line.	eeth. Do not en	iter the mode or dy	ying, such as cardiad	rof respiratory arn	est, ic,	4. 20	Intervel Bety Onset end D	ween Death
Physician /Medical		Immediate Cause (Final							1		
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dea he att	SICI	Pert II. Other eignificant conditions of	ontributing to death but not r	resulting in the u	underlying cause g	given in Pert I.	23b. Dld to	bacco use co	ntribute to	the cause o	of death?
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e law has b	npie								of c	deeth?	9436
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Physician: The this certificata rai director, pag	Be	25. Wes case referred to medical examiner?	Hamiltot				th (Check only on	10)			
0 0	2	1 Yes 2D No		☐ ER/Outpetie	nt 3LI DOA	-	ome 5 Reside			1)	
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I or Attending after death. Director: After d in by the fune	cat	2 Accident investigatio				Yes 2 No	DOS Lanatina (D)	to a day of Alicent		I Davis Abre	
l or Attendii aftar death. Director: A d in by the fu	T.	4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, st ecify)	treet, factory, office	0	28f. Location (SI City or Town		per or Hura	i Houte Numi	per,
To the Hospital or Attend within 24 hours after deal To the Funeral Director: completely filled in by the		29a. Certifier 12 Certifying Ph									
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ithin o the	Me	29b. Signature and title of certifier			29c. Licer	nse number	2	9d. Date signe	d (Month, I	Day, Year)	
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10		30. Name end eddress of person who	completed cause of death ("	tem 23e) /Tune	Print)	07-10		1111		. 197	
			60 en bever	e / /	220	16540 Freden	de Rd	?. Ga	ithe	yben!	un
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yea CANDILE D1995 BOBBI FEB 1999 20 = 41 25 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death HOSPITAL FALLSTON GENERAL FALLSTON HARFOND 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months Days Hours 1□M 2√2F Yrs 26 Jan. 30, 1999 Maryland Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1217 Bush Road 21009 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indien 11. Maritel Status Black, White, etc. Yes 30No Never Married 2 Married 1 Yes 25 No Specify: 3 Widowed 4 Divorced Black/Asian Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother'a Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Robert (nmn) Diggs Candelaria Jimenez Celebrado 19a, Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Robert Diggs - Father 1217 Bush Road, Abingdon, Maryland 21009 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Hilltop Service Corp. 3/2/99 4 ☐ Donetion 5 ☐ Other (Specify) Towson, Maryland 22. Neme end Address of Facility Howard K. McComas III Funeral Home, P.A. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Betw Onset and Death Immediate Cause (Finel CHF disease or condition resulting in death) Due to (or es e consequence of) PDA SD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): TRISOMY 18 Due to (or es e consequenca of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 00 1 Tyes 2 Thou 25. Was case referred to medicel examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2□ No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred NA 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident NA 6 Could not be 3 Suicide

Examiner physician and s the burial-transit certificate be axecuted Division of Vital Records. P.O. Box 68760. 60 attending | The law requires that the death by the stached 5 signed b peed has la 2 i certificata ha or Attending Physician: after death. this After Director: J To the Hospital of within 24 hours at To the Funeral D completaly filled in

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

Directo

Funeral

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Completed

with the Maryland

permit. Pages 1 and 2 should be filled within 72 hours after death v. Department of Health and Mental Hygiena. If them 27 is marked other than "near injury or other traumest."

Physician/Medical Examiner þ Completed Be 10 Certification:

edical

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and the basis of the cause (s). and menner stated. 29b. Signature end fitte of certifier

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

My 21014

29c. License number DME

OCMU

BELAN

25

29d. Date signed (Month, Dev. Year)

address of person who completed cause of deeth (Item 23e) (Type, Print)

LABHO 218 FULFORS MO

31. Date filed (Month, Day, Year) MAR 0 2 1999 32. Registrar's Signature

State Registrar

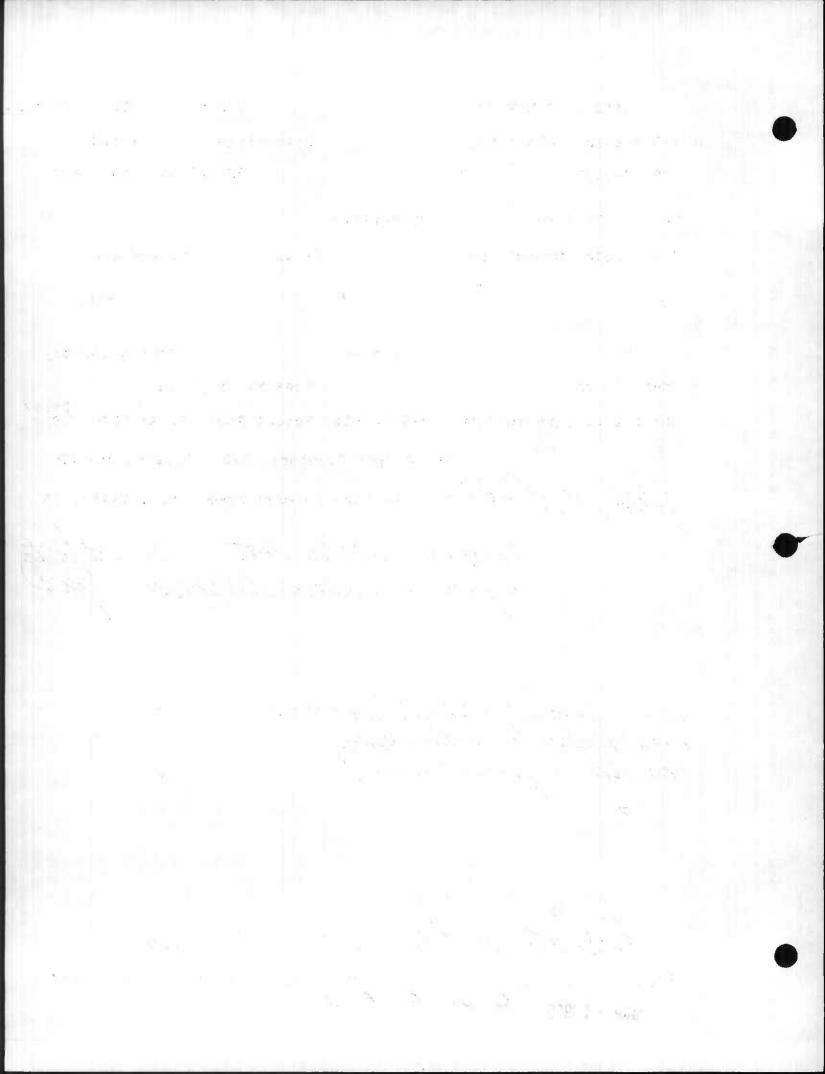
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Funeral Director		217-26-2	904	1 ☐ M 2√2 F		69 Yrs.	Months Day		Min. (Date of Birth Month, Day an. 28	3, 1930	Mar	lace (State or Foreign itry) yland
pu *	-	Usuel Residence of D	ecedent 10b. County		1.	Oc. City, Town or	Location					1	0d. Inside City Limits
f sho	0	MD	н	arford		Bel	λir						Yes 2□ No
28e	Director	10e. Street and Numb		ariora			10f. Zip Code				10g. Citizen of V	What Coun	itry?
3a o		481 Mod	res Mi	ll Road			21014				U.S.A.		
	2	11. Marital Status 1 Never Married 3 4 Vidowed 4		Armed d 1 ☐ Ye it Yes,	ecedent Ev Forces? es 2X No Give r Dates:	er in U,S.	Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 No		n? (Specify Puerto Rica	Yes or No- n, etc.)	Blac	a - Americ ck, White, : Whi	etc.
leal E	Completed by	1	5. Decedent's	Education	-40	16a. De	edent's Usual Occ e kind of work don	upation	form data a		16b. Kind of B	usiness/Inc	dustry
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er this contained are directly		1 ☐ Yes 25 No. 27. Manner of Death		28a. De	te of Injury	2 ER/Outpat	ent 3LI DUA	4 LI Nurs	-	, ,	dence 6 Oth		у/
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al Director: After tied in by the Tunera	Cer	4 ☐ Homicide		bu	ilding, etc.	(эреспу)				City of 104	m, State)		
To the Funeral Director: After this certific completely filled in by tha luneral director,				caminer: On the		xamination and/or	ath occurred et the investigation, in my						
within To the comp	-	29b. Signeture and tit	le ot certifier				29c. Lice	nse number			29d. Date signe	d (Month,	Day, Year)
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5	-	30. Name and addres	s of person w	no completed ca	ause ot dea	th (Item 23a) (Typ	e, Print)			1			nd, 1999 mp 2104
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State		31. Date tiled (Month,	Day, Year)	32	. Registrar	s Signature							

Registrar

State of Maryland / Department of Health and Mental Hygiene

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4	/Medica Examine		4a Facility Neme (If r							4b. City, To	own, or Lo	ocation of Deeth	4c. Count	y of Death		
4			419 Whee	eler Sc	hoo1	Road				Pv1	esvi	111e	На	rfor	ď	
	Funeral Director		5. Social Security Nur 170-24-1	nber 6. S		7. Age (In y		day) If Undi Months	er 1 Yea Day	r If Under		8. Date of Birth (Month, Dey 6/12/1	Year)	9. Birthp	place (Stete or ntry) yland	
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Division	s efter of Direct and	Certification:	4 Homicide	datarmined	289. Plac	te of Injury - A ding, atc. (Spa	it home, fari ac <i>ify)</i>	n, street, facto	ory, offic	e		28f. Location (S City or Tow		iber or Hur	ai Houle Numi	107,
	Hospi 24 hou Funer tely fill	edical		Certifying Ph	niner: On the I											
	To the To the comple	Me	29b. Signature and M	le of certifier	Am.	nost	Ell	103	9c. Lice	nse number	324		3/3/9		Dey, Year)	
	V		30. Name and addres	s of parson who	completed ceu	use of death (i	itam 23a) (1	ype, Print)	HIT	FOR	DA	Min	F0/87)	Van)	2/160	
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State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death		Reg. No.	OC	1 4 4
Physician /Medical	LAMES THUMAS	DRESHER	SR.			2. Dete of De Month Februa	Dey	Year 1999	3. Tima of Death
Examiner	An English Storm of Manch Innthisting of				4b. City, Town, or Fallsto			of Death	3
Funeral Director	5. Social Security Number 6.1 160-12-1769	-	last birthday Yrs.	Months Deys		8. Date of Bir	th ly, Year)	9. Birthpl Count	ace (State or Foreign hy) Sylvania
yland	Usuel Residence of Decedent 10a. Stete 10b. County	10c, C	ity, Town or L	ocation				10	Od. Inside City Limits
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with u	10e. Street and Number 1337 East MacPha	il Dood		10f. Zip Code 2101	16		10g. Citizen of 1	What Count	ry?
2 2 2 3	11. Meritel Stetus 1 Never Married 2 Married	12. Wes Decedent Ever in Armed Forces? 1 Yes 2X No If Yes, Give Yeer or Detes:	J,S. 13.	Wes Decedent of Hill Yes, specify Cuba		Specify Yes or No to Rican, etc.)		ce - America ck, White, e	elc.
ygiene. Ygiene. Ygiene. Ygiene. Ygiene. Ygiene. Ygiene.	15. Decedent's E (Specify only highest gr	ducetion ade completed) College (1-4or 5+)	(Give	dent's Usual Occup a kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of B	usiness/Ind	ustry
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Ment Ment	John (nmn)	Dresher	10h Mail	ing Address (Street	Agnes	(nmn)	Johr	nston	Codal
- A .	19a. Informent's Name/Reletionship Virginia M. Dres			ing Address (Street E. MacPha				1015	C006)
omil. Pages I and Department of Health Important: if the Ir Ingling or other Ir Ince.	20e. Method of Disposition 1 X Buriel 2 Cremetion 3 [4 Donation, 5 Other Speci	20b. Removel from Stete	Plece of Disp cemetery, cre	osition (Name of emetory or other ple	ce)	Dete	20c. Location	City or To	
permit. P Departmet Importan any injur BDCs.	21: Signature of Funeral Sention Lice		P E	Memorial 2. Name end Addre Howard K. 317 Cokes	ss of Fecility McComas	III Fun	eral Hon		
Physician /Medical Examiner	23a. Part Enter the disease or conshock, or heart failure. List only immediate Cause (Finel disease or condition resulting in deeth)	. ACUTE							Approximete Interval Between Onset and Deeth
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tal or Attending P is after death. al Oirector: After to in by the funeral Certification:	3 ☐ Suicide 6 ☐ Could not be determined			reet, fectory, office		28f. Location (City or To	Street and Numi wn, State)	ber or Rura	Route Number,
To the Hospital or Attend within 24 hours after death To the Funeral Directors: completely filled in by the Medical Certificat	29e. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician: To the best of my kn niner: On the basis of examin end manner steted.							
To th To th comp	29b. Signeture end title of certifier Delus	· Vasas	/	29c. Licens	603L		29d. Date signe		1111
30	30. Neme and address of person who	completed cause of death (Ite	m 23a) (Type	, Print)	9 - 7 0		EVICUA		28, 1999
State	31. Dete filed (Month, Day, Year)	3. Registrar's Sign	eture	11 .					1,511
Registrar	MAR - 4 1999	1 Parent	Ø.	Sports					

DHMH 16 Rev 6/95

James Dresher

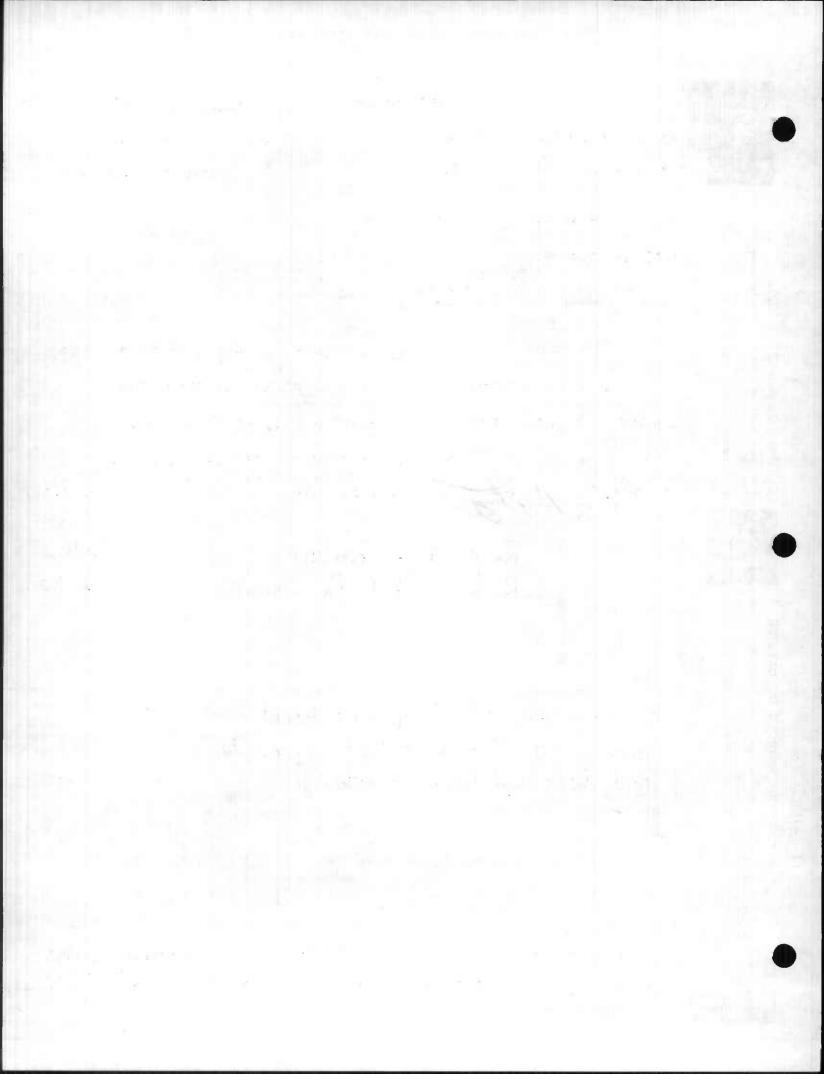
- 414

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March **Physician** 45 AM DANNER ALBRIN DUVALL /Medical 4e Facility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** FALLSTON GENERAL HOSPITAL FALLSTON HARFORD If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthpleca (State or Foreign **Funeral** Months Deys 1∭ M 2□ F 214-28-0259 67 Yrs. 9/24/1931 Director MARYLAND Usual Residence of Decedent tha Maryland 10a Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or frems 23s or 28s-f show treumstic event, the Modical Examiner must be notified at 1 Yas 2X No Directo MD. HARFORD FALLSTON 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 2117 HAMPTON COURT 21047 Funeral USA. death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ NoKOREAN If Yes, Give Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. permit. Pagas 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiana.
Important: If Item 27 is marked other than "naturel", or hanny injury or other traumment. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE PV 3 ₩ Widowed 4 Divorced Year or Dates: CONFLICT 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15 Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elamentary/Sacondary (0-12) Collaga (1-4or 5+) 6 CONSTRUCTION HEAVY EQUIPMENT OPERATOR 18. Mother's Name (First, Middle, Malden Surname) 17. Fether's Nama (First, Middle, Last) DANNER A. DUVALL MARIAN L. ROBERTSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERT E. DUVALL -BROTHER 2117 HAMPTON CT., FALLSTON, MD. 21047 Saltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) PINE GROVE CEMETERY 3/4/99 MT. AIRY, MD. 22. Nama and Address of Fecility FLETCHER FUNERAL HOME 21. Signeture of Funeral Service Licensae 254 E. MAIN ST., WESTMINSTER, MD. 21157 that caused tha death. Do not enter the mode of dying, such es cardiac or raspiratory arrast, Approximate Intarval Between Onset and Deeth **Physician** /Medical Immediete Causa (Final diseese or condition resulting in deeth) Examiner Examiner hours ician and burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last physician a Box 68760, Physician/Medical Due to (or es e consaguence of): Pert II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown ongestive 2 24b. Were autopsy findings eveilable prior to completion of causa of daeth? 24e. Wes en eutopsy performed? Completed Regurgitation 1 Yes 2 No cartificata 1 ☐ Yes 2 ☐ No and 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only ona) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Date of Injury (Month, Day Yeer) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? Aftar 1- Naturel Injury 5 Pending death. 1 ☐ Yes 2 ☐ No Invastigation 2 Accident or Attend after death Director: / 6 Could not be detarmined 3 Suicide Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral D 29e. Certifier 1🗹 Certifying Physician: To tha best of my knowledga, death occurred et the time, date end plece, and due to tha causa(s) and mannar es stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta end place, end due to the causa(s) and manner stated. To the I within 2 29b. Signatura and title of continu 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Nama and addrass of parson who completed cause of deeth (Item 23e) (Type, Print) Kbercte, er

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 3 1999

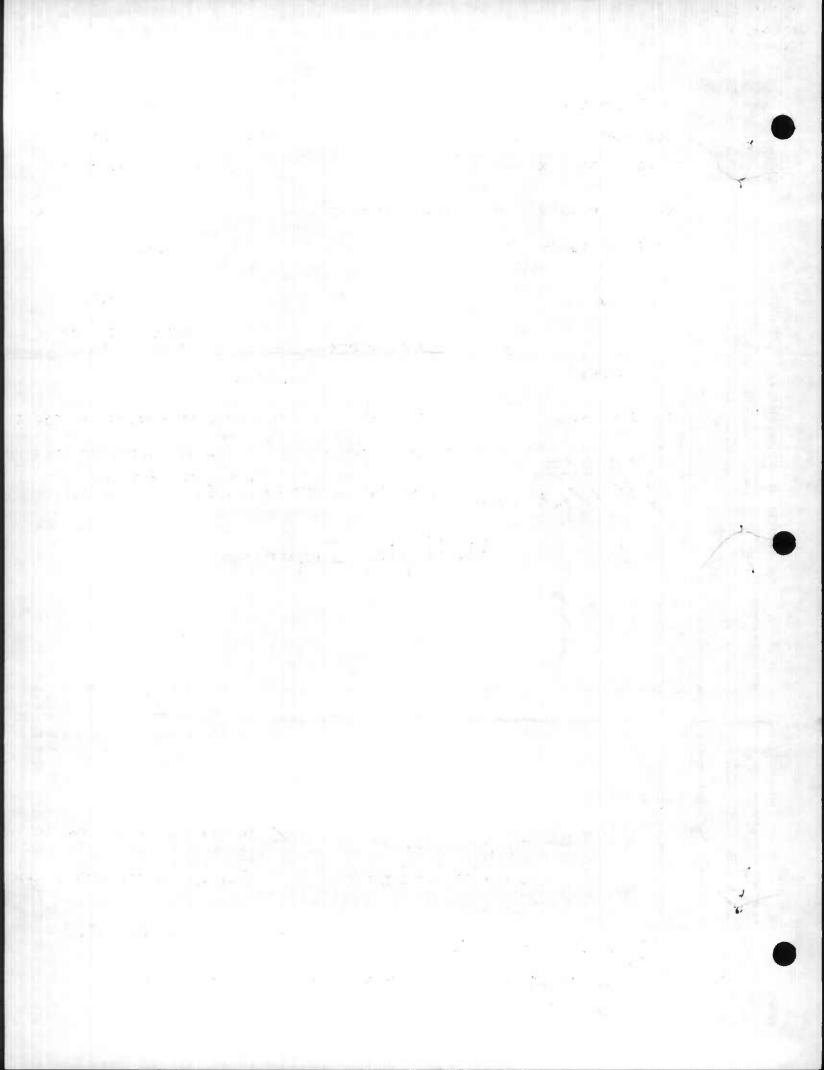
OUVAIL DAWS



DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

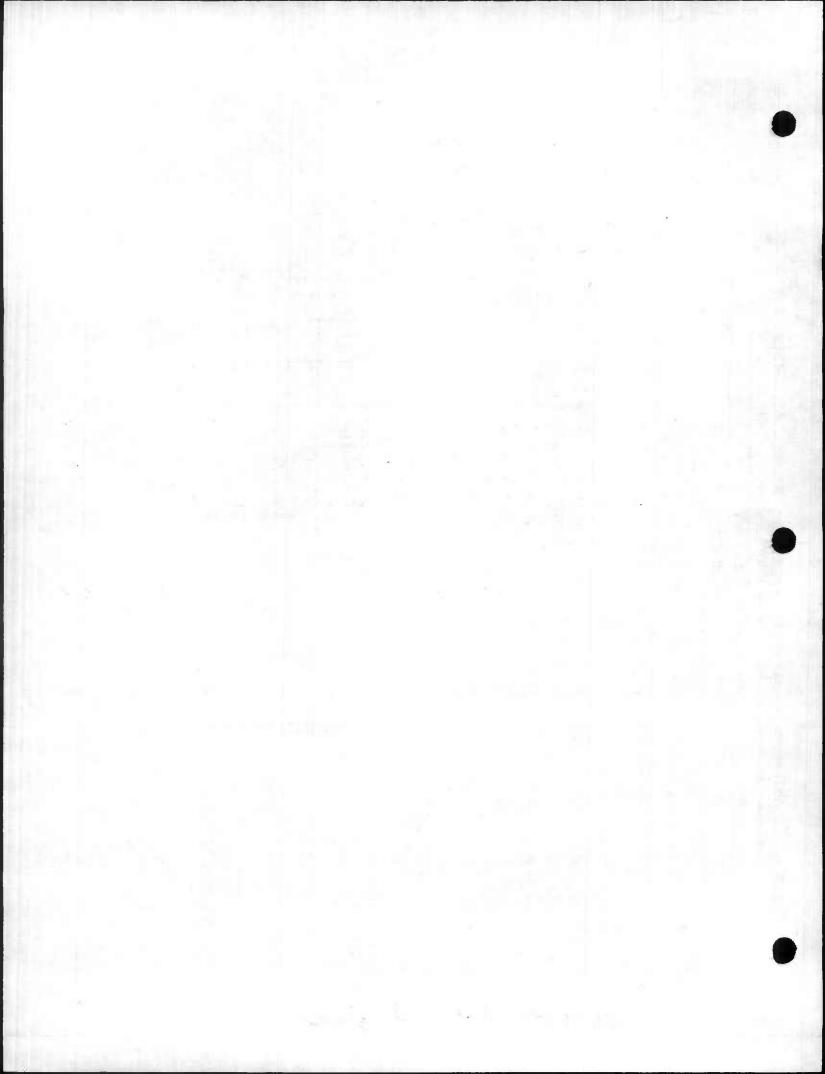
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			15. Deceda	int's Educ ast grade	cetion complated) Collega (16a. D			pation during most of w d) DRIVER	orking	GI	Sb. Kind of Bu	usiness/Ind	dustry
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	19	9a. Informant's N			pe, Print)		1112			and Numbar or I					Coda) ,WV 2541
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Medical Certification: To Be Completed by Physician/Medical Examiner	Pa 25	equantially list coany, leading to in death) equantially list coany, leading to in buse. Entar Undausa (Disease or at initiated event sulling in death) ort II. Other elgnifications of the coany leading in death) ort II. Other elgnifications of the coange of the coa	(Final on Millions, madiate arriving Injury Stast ficant conditions on the first conditions on the fi	tions conditions conditions conditions conditions conditions conditions conditions and the conditions are conditionally conditions and conditions are conditionally conditions are conditionally conditions are conditionally conditionally conditions are conditionally conditionally conditions are conditionally co	lospital: 1 = 28a. Data (Mon build S TV	Dua to Du	deeth. Do not to (or as a control or as a cont	nsequence of the underlying the unde	DOA Oth 28c. Inju tory, office	van in Pert I. 26. Placa of Dhar: 4 Nursing ry at rk? I Yes 2 No	23b 24a aath (Check Homa 5 28d. Das Driv 28f. Loca 28f. Loca ce, and due 1	Did tobe 1 Yes Was an performe 1 Yes only ona) Rasidan cribe how tion (Streor Town,	ecco use con 2 No eutopsy 2 No co 6 Oth Injury occurr Stata) sa(s) and ma	ar (Specified of the Control of the	Approximate Interval Between Onsat and Daath of the cause of death? othe cause of death?



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	1. Decedent's Nar	me (First, Middle, Las	t)		Cert	ificate c	of Death	2. Date of De	Reg. No.		3. Time of Death				
sician	BETT	Y	JEAN		DEJC	Y		Month MARCH	2, 1999	Year	1:40 AM				
cal ner	4a Facility Name	(If not institution, give	street and number	r)			4b. City, Town, or		_,		I.40 AII	-			
al or	5. Social Security 220-80-3	Number 6. Se 11	Genesis ElderCare OEX. 7. Age (In yrs. last birthday) 71 Yrs.			If Under 1 Ye Months Da	he Days Hours Min		8. Date of Birth (Month, Day, Year) 9.		ICO 9. Birthplace (State or Foreign Country) EST VIRGINIA				
	Usual Residence	of Decedent 10b. County		10c. City,	Town or Loca	ation					d. Inside City Limits				
ector	MARYLAND	YLAND WICOMICO SAL								1⊠Yas 2□No					
Direc	10e. Street and Number 10f. Zip Code							hat Countr	y?						
	2111 NOF	RTHWOOD DR				21801		USA							
by Funeral	11. Marital Status 1 ☐ Never Mai 3 ☐ Widowed	Armed Forces 1 Yes 2 X If Yes, Give	Armed Forces? If Yes,		Yes, specify C	s Decedent of Hispanic Origin? (Specify Yes or Nes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 [] No Specify:			No- 14. Race - American Indian Black, White, etc. Specify: WHITE						
Completed	(Spe	15. Decedent's Educify only highest grad	t's Education st grade completed) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) HOMEMAKER			Orking 16b. Kind of But							
Be C	17. Father's Name	(First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden Sumame						
TOE	ELLIS HE	ENRY WALTO	N				MAMIE P	EARL WAI	LTON						
		Neme/Retationship (T					eet and Number or R								
	20a. Method of Di	Cremation 3 🗆	Removal from State	e Cer	ace of Disposi metery, crema	tion (Name of atory or other p	place)	Date	JRY, MARY 20c. Location - 6						
		5 Other (Specify uneral Service Libera		MD E			VET. CEM	3/4/99	BEULAH,	MARY	LAND	_			
	21. Signature at 1	digital sarvice goard	100	000	ZEI	LLER FU	dress of Facility UNERAL HOM								
1	23a Part Enter	the disease or comp art failure. List only o	Scations that course	ad the death	121	2 OLD	OCEAN CIT	Y ROAD,	SALISBUR		21802 Approximate				
	Immediate Cause disease or conditi resulting in death	(Finat	G	lon	as a consequ	lone	27				Interval Between Onset and Death				
aminer			. De	man	Sun					16	un.				
edical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):														
Physician/M	Part It. Other alon	ificant conditions co	ntributing to death	hut not result	ting in the und	ledving cause	given in Part I	23b. Did	tobacco use con	tribute to 1	the cause of death?				
by Phys							1 Yes 2 To 3 Probably 4 Unknown								
Completed l										/as an autopsy enformed? 24b. Were autopsy findings available prior to completion of cause of death?					
Co								10	Yes 20 No	1 🗆	Yes 2□ No				
8	25. Was case refe examiner?	/	Mognital				200	eath (Check only	one)						
T.	1 Yes 20	2240	Hospital: 1 Inpat		R/Outpatient 28b. Time of				lesidence 6 Other (Specify)						
Certification:	27. Manner of Death 1 ☑ Netural 5 ☐ Pending investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide				Injury	Injury Work? M 1 Yes 2 No			28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only	1 Certifying Phy	raician: To the best	t of my know	fedge, death o	occurred at the	o time, date and plac	e, and due to the	cause(s) and mar	nner es sta	ited.				
Aedicai	one) and manner stated.														
2	29b. Signature and	29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Day, Year)							
	1/	M	11-			1	2954	5	1/2/9	9					
	30. Name and add	lress of person who o	ompleted cause of	death (Item 2	23a) (Type, P	rint)			//						
tate	31. Date filed (Mod	I ROBINS, I		trar's Signatu		EALTHWA	Y DR., SAL	ISBURY,	MD. 2180)4					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Amend #5,3/5/99, BMW, Mont. Co Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** MARCH 1, 1999 EATMON GENA NORWOOD 3:30 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner 16960 OAKMONT AVENUE MONTGOMERY GAITHERSBURG If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 21216740-6591 Birthplaca (Stata or Foraign
Country) 7. Aga (In yrs. last birthday) **Funeral** 1□ M 20 F 57 Yrs. **Director** May 28, 1941 Washington, DC Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e Street and Number 10f. Zip Coda than "natural", or items 23s or the Medical Examiner must be a 16960 Oakmont Avenue 20877 United States Funeral permit. Pages 1 and 2 should be filled within 72 hours after dea Department of Neath and Mental Hygiene. Important: If then 27 is marked other the any injury or other trause. 12. Was Dacadant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b Kind of Business/Industry ASBURY Elamantary/Secondary (0-12) Collaga (1-4or 5+) Methodist Village Executive Secretary 12 17. Fether's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be George Samuel Parsons Olive Smith 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 110 Duvall Lane, #202 Gaithersburg, MD Kimberly Eatmon, Daughter 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 2 Cramation 3 Ramoval from State 1 Buris March 3 4 □ Donation 5 □ Othar (Specify) Metropolitan Crematory 1999 Alexandria, Virginia 22. Nama and Addrass of Facility DeVol Funeral Home 20877 10 East Deer Park Dr., Gaithersburg, MD Janus or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Entar tha disas Approximata Interval Batween Onset and Death **Physician** /Medical Immediata Ceuse (Final disaasa or condition resulting in death) 941 Examiner Due to (or as a consequence of): Tomsko M.D. physician and the bunel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disaase or Injury Dua to (or as a consequence of): P.O. Box 68760. thet initiated events rasulting in death) Last Dua to (or as a consequanca of): use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Cia Physi Yee 2 No 3 Probably 4 Unknown ric Division of Vital Records. e Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? certificate has 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No M. J. director. Attending Physician: 25. Wes case referred to medical axeminar? 26. Plece of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) Leased by N Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant after deatl 6 Could not be datermined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 ☐ Homicide 0 filled ! 24 hours a Re1 29a. Cartifiar 1🛣 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the causa(s) and manner as steted. To the Hosp within 24 hor To the Fune completely fi (Check only 2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. P

**Cleared State Registrar

Stephen Hellman, M.D., 31. Data filad (Month, Day, Year) MAR 03 1999

30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

29b. Signature and little of certifier

6240 Montrose Road, Rockville, Maryland 32. Registrer's Signeture

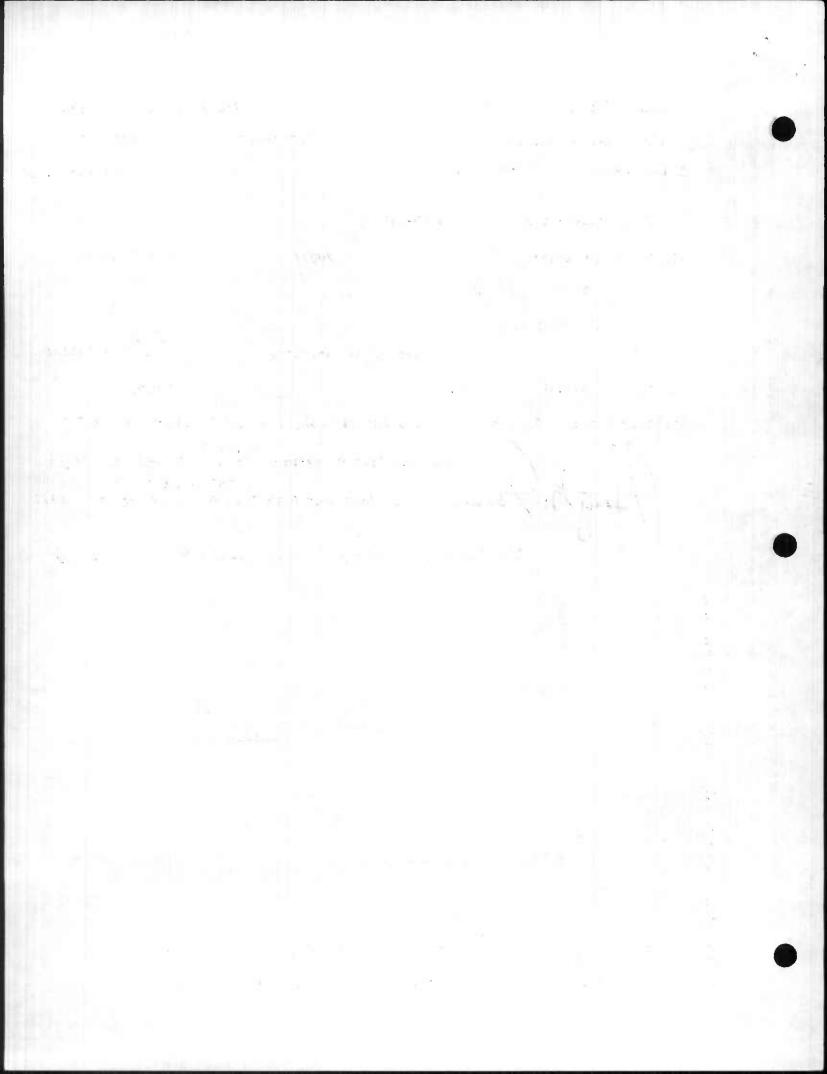
29c. Licansa number

29d. Data signed (Month, Day, Year)

MARCH 2, 1999

20852

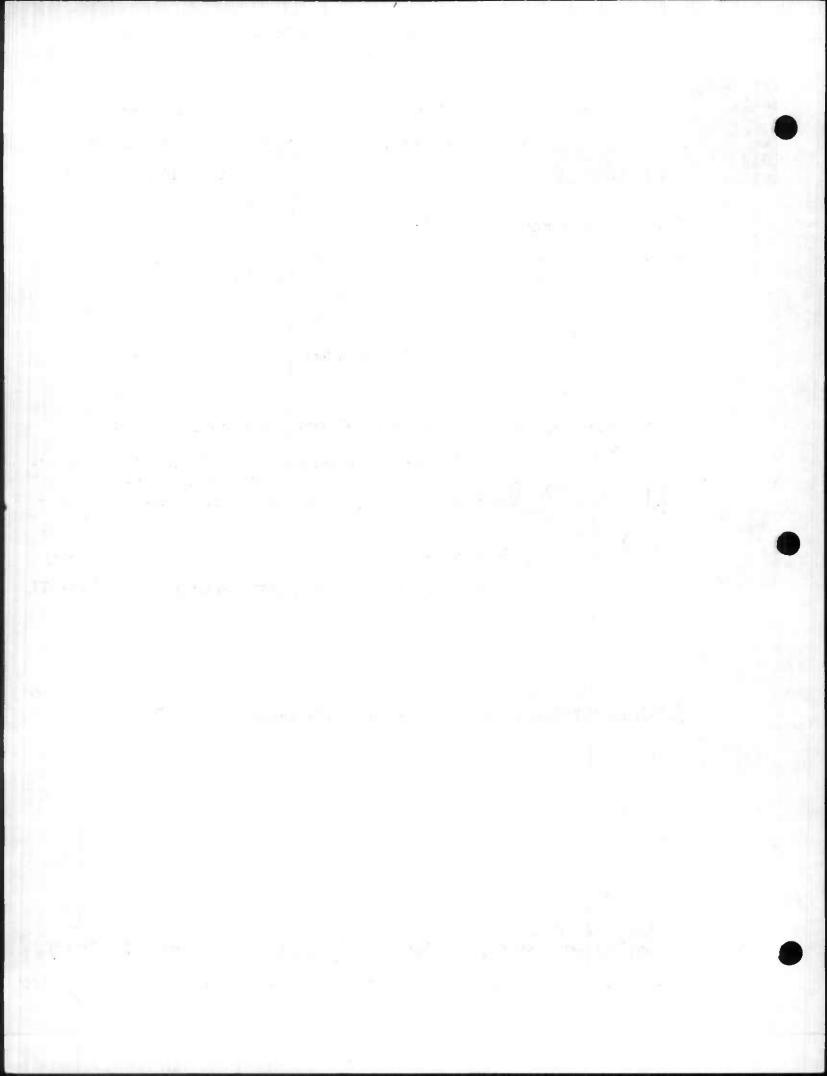
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П	Dhysia	ion	1. Decedent's Nama (First, Middla, Last)					2. Data of Deet Month	th Day	Year	3. Tima of Death	
Physic /Med			Francis Leroy Eisel					March		99	1:40 AM	
)	Examir		4e. Fecility Nama (If not institution	on, giva street and numbe	er)		4b. City, Town, or L	ocation of Daath	aath 4c. County of Deeth			
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	Funeral		o. Social Security Number		Aga (In yrs. last bir	thday) If Undar 1 Yas Months Day	r If Under 24 Hrs. s Hours Min,	8. Data of Birth (Month, Day,	Vaar)	9. Birthp	laca (Stata or Foraign	
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	-		10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Fart! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate									
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month Day WALTER MARCH 1999 ENGLER 2:05 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4005 LAYTONSVILLE ROAD MONTGOMERY OLNEY 8. Dete of Birth (Month, Day, Year) SEPT.12,1927 if Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) Min. Days 12M 2DF Months Hours MONTANA 517 26 5236 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 22 No MD. MONTGOMERY OLNEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 4005 LAYTONSVILLE ROAD 20832 12. Was Decedent Ever in U,S. Armed Forces? 1. Yes 2 NoWWIII If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Year or DatesKOREAN WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) MEDICAL RESEARCH MILITARY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WALTER F. ENGLER, SR. BLANCHE F. PILON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4005 LAYTONSVILLE ROAD, OLNEY, MARYLAND 20832 THELMA M. ENGLER, WIFE 20b. Placa of Disposition (Name of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL 3/8/99 ARLINGTON, VIRGINIA 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth phons immediate Ceuse (Final - Hodakin's disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed' 20 No 1 Yes 2 No 1 Yes 26. Piace of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner** physician and the burial-transit that the death certificate be executed

pennit. Page Department Important: If any Injury or

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itema 23 ury or other traumatic event, tre Manical Examples must

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records.

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Hospital or Attanding Physician:

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Examiner attending pl been signed by the s should be detached is certificate has director, page 2 funeral

Physician/Medical py Completed Be 2 Certification:

25. Was case referred to medica examiner's 1 Yes 2 No

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

28a. Date of injury (Month, Day Year)

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29a. Certifier (Check only one) 29b. Signature and title of certi

29c. License number D45880 29d. Date signed (Month, Day, Year)

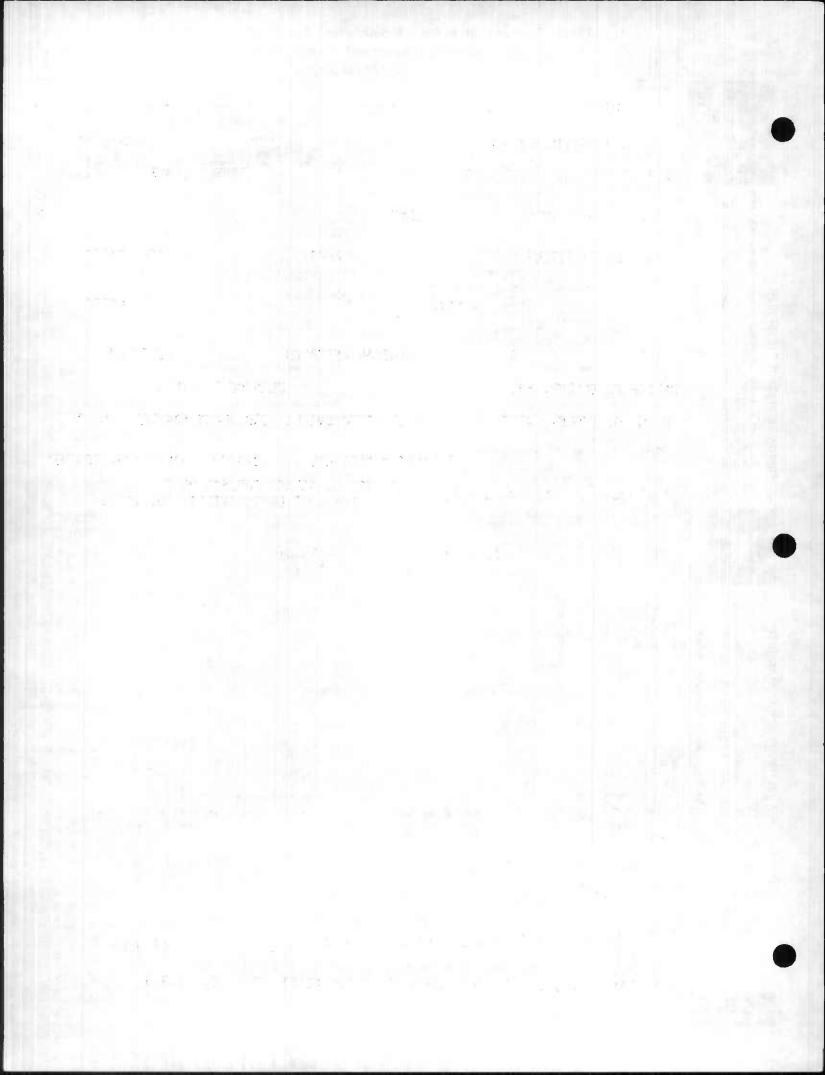
30. Neme and and iss of person who completed cause of deeth (Item 23a) (Type, Print)

CONN. AVE., SUITE 606, KENSINGTON, MD. LEON HWANG, M.D., 10400 31. Date filed (Month, Day, Year)

State Registra



DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #26,3/5/99, BMW, Montg. Co per physician Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth Day **Physician** 1412 February 28, 1999 Diana Stevens Falk /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year) If Under 1 Year 5. Social Security Number Birthpleca (Stete or Foraign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 1□M 2♥F Months Deys 57 Yrs. Aug. 11, 1941 Washington, DC 214-42-6260 Director Usual Residence of Decedent with the Meryland 10c. City, Town or Location 10a Stata 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or items 23s or 28s-f shot traumstic event, the Modical Exercipat must be notified at 1 ☐ Yes 2X No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Permit. Peges 1 and 2 should be filed within 72 hours after death v. Depertment of Heelth and Mental Hygiene.

Important: if them 27 is marked other than "natural" and poten.

Once. 15016 Wellwood Road 20905 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Black, White, etc. 1 □ Navar Marriad 2 TX Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decadant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Daniel G. Falk College (1-4or 5+) Elementery/Secondery (0-12) Co-Owner and Associates 18. Mother's Neme (First, Middle, Maiden Sumema) 17. Fethar's Neme (First, Middle, Last) Francis Stevens Ida Boyd 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daniel G. Falk (husband) 15016 Wellwood Road, Silver Spring, MD 20905 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cramation 3 Ramoval from State ncoln Cemetery 3/4/99 Brentwood, MD

22. Name end Address of Facility Francis J. Collins Funeral
Home, Inc. 500 University Blvd. West 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signeture of Funerel Service Licensee 20901 Silver Spring, MD Uben 23a. Pert1. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HEMORRHAGIC GASTRITIS Examiner Due to (or es e consequença of) Examiner physician end s the buriel-trens Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of). certificate be Physician/Medicai Dua to (or es a consaquance of) 98 attending law requires that the deeth Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert i. 23b. Did tobacco use contribute to the cause of death? the ed by th 1 Yes 2 No 3 Probably 4 Unknown DiAbetes Mellitus, non-insulmi dependen 2 24b. Were eutopsy findings eveilable prior to 24a. Was en eutopsy performed? Completed peen completion of cause of death? this certificate hes The 1 Yes 2 □ No 1 No 2 No Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home Thesicence 6 Other (Specify) 10 1 Yes 2 No : After this e funeral c 28a. Date of Injury (Month, Day Yaar) 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: or Attending Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide edicai Exertifying Physician: To the best of my knowledge, daath occurred et the time, dete end plece, and due to the ceuse(s) and manner as steted. 29e. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner stated.

Box 68760. P.O. Division of Vital To the Hospins.

within 24 hours effer deeth.

To the Funeral Director: Aftr the

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State

Registrar

29b. Signature and little of certifier

29c. Licanse number

29d. Date signed (Month, Day, Year) MARCH 1, 1999

30 Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Hampsthae AVENUE 11161 NEW

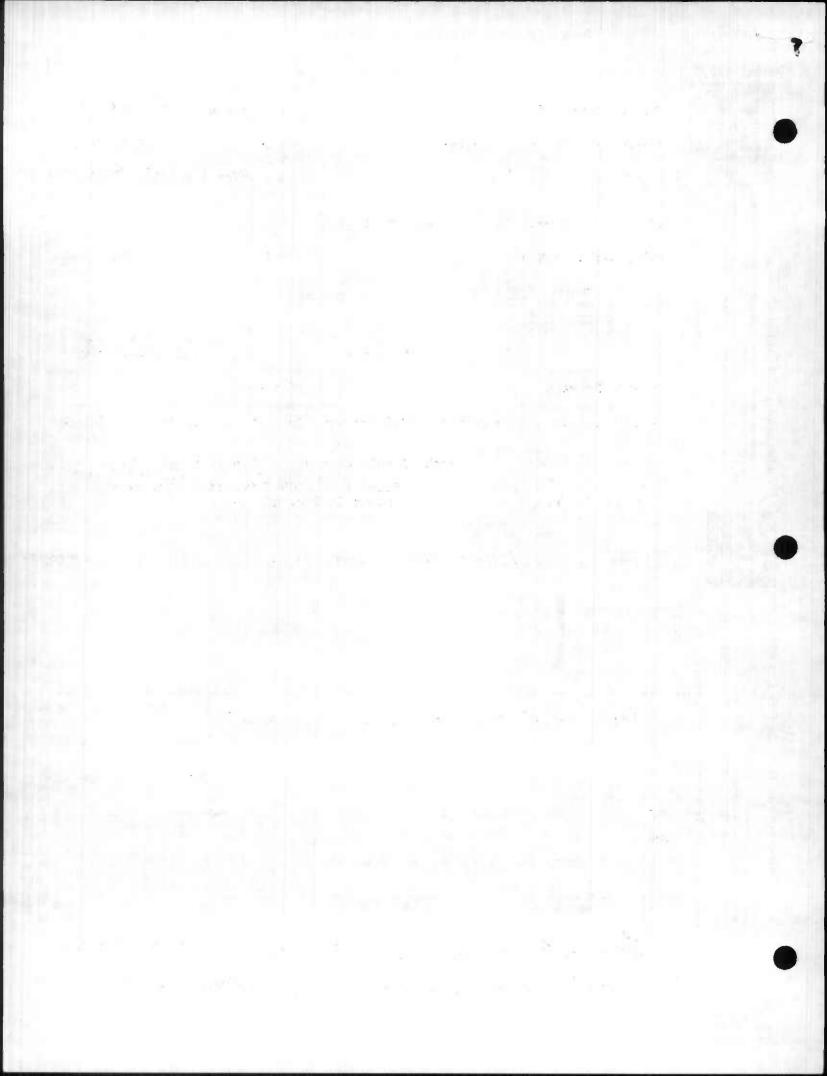
Jerome, Schnapp, MD Maryland 20904 Silver Spring

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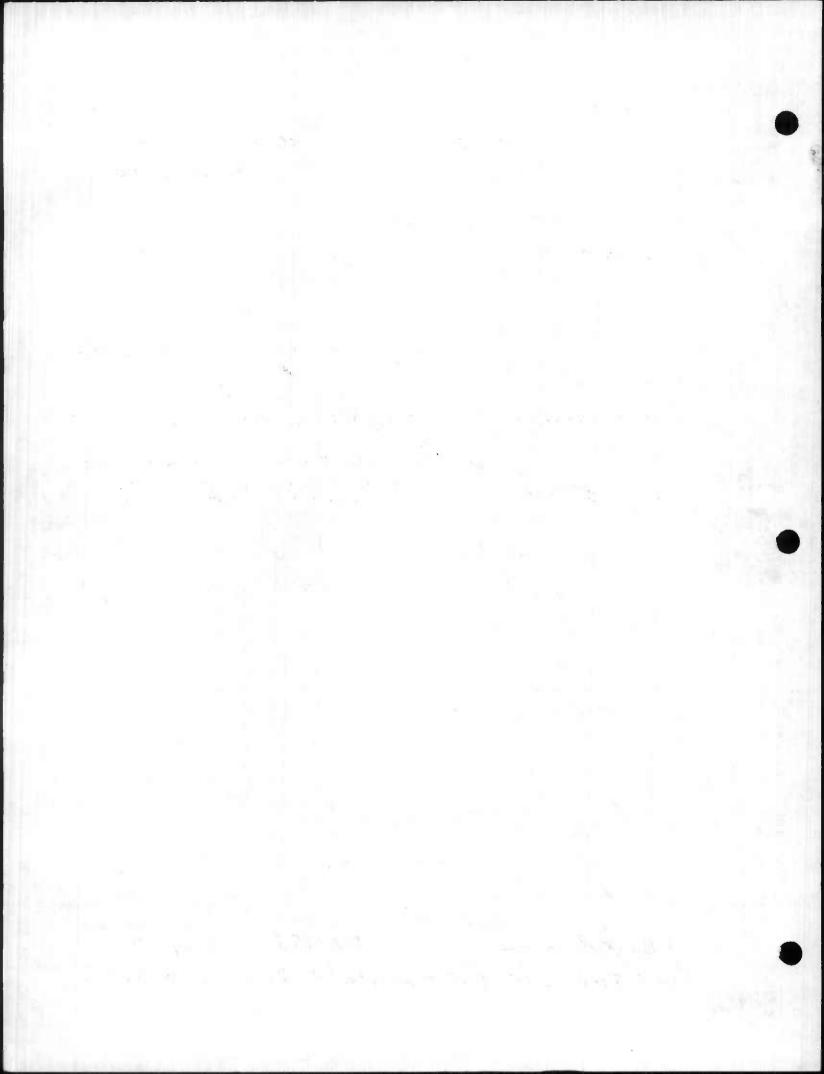
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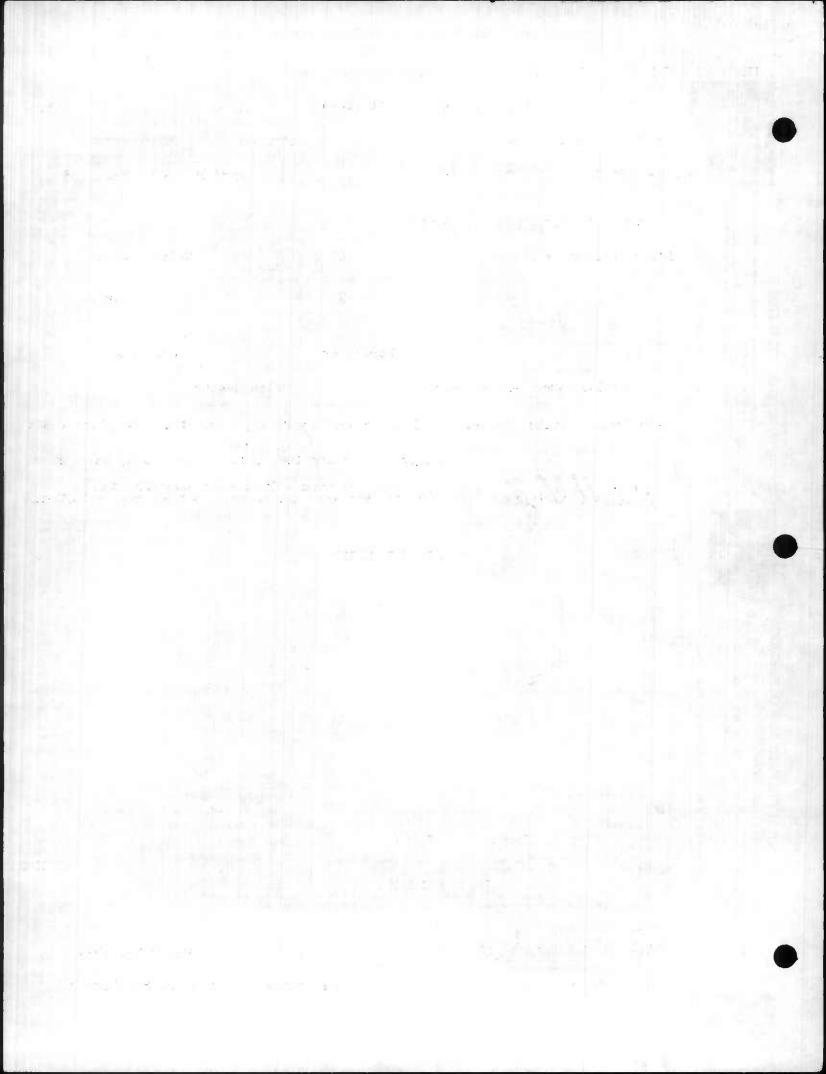
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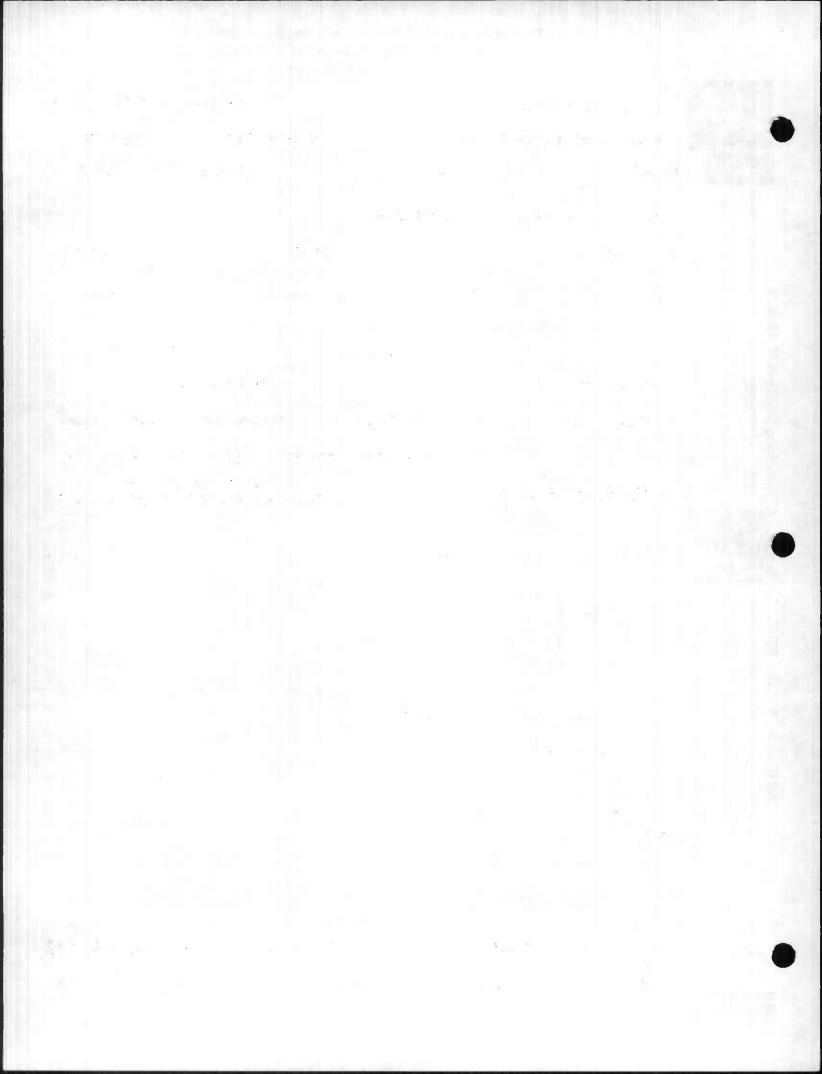
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ner	4a Facility Name (If not institution,		r)			- 1	4b. City, Town, or	Location of Dea	th 4c. C	County of Death	
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by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forcas	? No		Yes, speci		dispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)		Black, White	, etc.
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To B	Franklin	Davidson Ga	rrett				Hele	n Wagne	r		
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	Susan Garrett F		or								land 20874
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	23e. Perf. Enter the disease, or shock, or heart feilure. List	complications that cause	ed the deeth	. Do not anter	the mode	e of dylr	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 25, 1999 **Physician** 9:25pm Helen Kussin French /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Gaithersburg Montgomery Wilson Health Care Center If Under 24 Hrs. Hours Min. If Under 1 Year 9. Birthplace (State or Foreign Country) New York 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 2, 1911 **Funeral** Hours 1 □ M 2 耳 F Months Days 097-07-1146 87 Director Usual Residenca of Decedent with the Maryland Johnit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic svent, the Medical Examiner must be northed at page. 10a. State 10c. City. Town or Location 10d. fnside City Limits 10b. County Md. Gaithersburg 1 No Yes 2 No Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 United States 201 Russell Ave Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White PV 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Teacher Education 5+ 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Otto Kussin Marie Kammerer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 14 Sunnyview Ct. Germantown, Md. 20876 Charles T. French Jr. (Son) 20b. Place of Disposition (Name of 20a. Method of Disposition Feb. 26 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 1999 Metropolitan Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home evelis 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 1 week DNoumonia disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s tha burial-transit certificata be executed Sequentially list conditions, if any, leeding to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of): use as the attending phed for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dfd tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Rheumaloid Division of Vital Records. þ 24b. Were autopsy findings eveileble prior to 24a. Was an autopsy Completed peen completion of cause of death? has 2 NO 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Wes cese referred to medical examiner?
1 ☐ Yes 2 2 → 100 funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyaicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edicai To the within 2 To the I 29b. Sign and end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number (10 0 30. Neme address of parson who completed ceuse of death (Item 23a) (Type, Print) RusskeL MELMICL 31. Date filed (Month, Day, Year) 32. Registrer's Signature State MAR 01 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** EDYTHE I. FRYMIRE 2:00PM FEBRUARY 25, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPRING HOLY CROSS HOSPITAL MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign SEPT 12, 1909 PENNSYLVANIA 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 10 M 20 F 89 577-01-8241 Yrs. **Usual Residence of Decedent** 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 1 Yes 2 No MONTGOMERY Director SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11215 OAK LEAF DRIVE APT. 709 20904 Funeral USA 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE p 3(☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT FEDERAL GOVERNMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 UNOBTAINABLE UNOBTATNABLE. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN BECK (ATTORNEY) 1301 K ST. N.W. DC 20005 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State ARLINGTON NATIONAL CEM. 3-4-1999 ARLINGTON, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility HINES-RINALDI 11800 NEW HAMPSHIRE 21 Signature of Funeral Service License AVENUE SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS SUDDEN disease or condition resulting in death) Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FEVER by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? DIABETES MELLITUS completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 89 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d, Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and titlefol certifier 29c. License number 29d. Date signed (Month, Day, Year) D-32332 FEBRUARY 27, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The law requires that the death certificate be executed Box 68760. P.O. Records. of Vital or Attending Physician: Division Hospital

Funeral

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permit. Pages 1 and 2 should be lile Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, pages.

Physician /Medical

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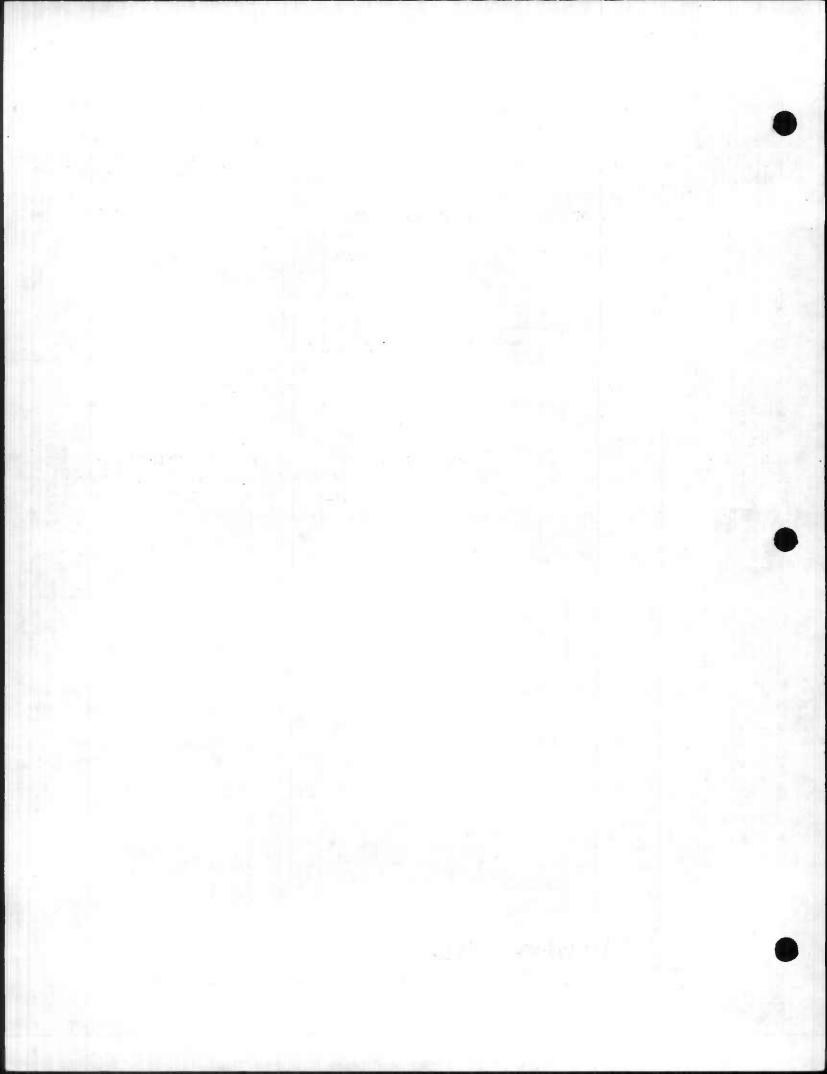
within 24 hor To the Fune completely fi

To the

State Registrar

31. Date filed (Month, Day, Year) MAR 03

S K GUPTA M.D. 9801 GEORGIA AVENUE #220 SILVER SPRING, MD 20902 32. Registrar's Signeture Rysera



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death March 1, ^{Day} 1999 Georgia Lucille Farmer 10:00 AM 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Forest Hill Mariner Health of Forest Hill If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) 8. Dete of Birth (Month, Dev. Yeer) 1 ☐ M 252 F Months Deys 216-66-5615 81 June 7, 1917 West Virginia Usuel Residence of Decedent 10e Stete 10c. City, Town or Location 10b Counts 10d. Inside City Limits 1 ☐ Yes 25 No Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 1419 Prospect Mill 21015 IISA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien. 11. Maritei Stelus Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3X Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Edward (NMN) Van Hoy Vera Elmore Henderson 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Charles R. Farmer/Son 194 Vineyard Drive, Port Deposit, MD 21904 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Mt. Zion Methodist Cem. 3/3/99 Bel Air, MD 22. Name end Address of Fecility HOWard K. McComas III Funeral Home, P.A. 21. Signature of Euneral Service Licensee 23a. Pentl. E. er the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one sause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were eutopsy findinga eveileble prior to 24a. Was en eutopsy completion of ceuse of death? 1 Yes 2 No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

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Hospital or Attending Physician:

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To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

The law requires that the death cartificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

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Funeral

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permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Example.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be Certification: To

25. Wes case referred to medical exeminer?

Other: 4 Sursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work?

1 Yes 2 100 27. Manner of Deeth 5 Pending investigation Naturel 2 Accident

28e. Dete of Injury (Month, Day Year) 6 Could not be

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28d. Describe how injury occurred 1 Yes 2 No

29a, Cartifier

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Certifying Physician-To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner es steted.

Madical Examiliar On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s)

29b. Signature and title of certifier

29d. Date signed (Month, Dey, Year) 29c. License number

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person woo completed cause of death (Item 23a) (Type, Print)

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31. Dete filed (Month, Day, Year) MAR - 4 1999 \$2. Registrer's Signeture

State Registrar

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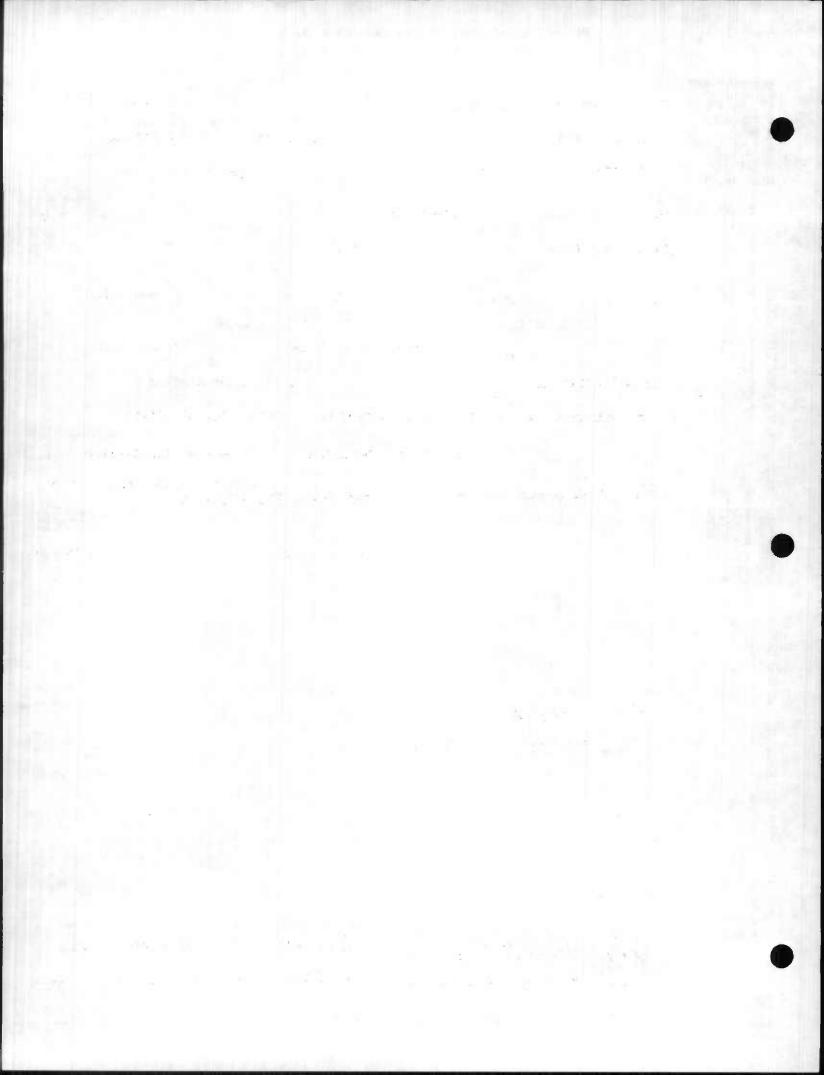
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey 1999 eer **Physician** 8:45pm 28 Frances Hammond Flayhart /Medical 4e Fecility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrest Hospice Baltimore Baltimore 8. Dete of Birth (Month, Dey, Year) 5. Social Sacurity Number If Under 1 Year | If Undar 24 Hrs. Birthpleca (Stata or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□XF Deys Hours 170-26-8734 83 Yrs. Director Feb 11 1916 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Carroll Sykesville 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 601 Concord Lane 21784 USA 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Meritel Status traumatic event, the Medical Examiner 1 Never Merried 2 Married 1 Yes 2 XNo Specify: specifywhite þ 3 ☐Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) al Hygiene. Elemantery/Secondery (0-12) College (1-4or 5+) registered nurse health care +418. Mothar's Nama (First, Middle, Meiden Surneme, 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be nert of Health and Mental Hammond McCormick Miriam Frances McKee 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Sue A. Silbaugh (daughter) 575 Gaither Rd., Sykesville, Md. 21784 20b. Piece of Disposition (Neme of cematery, crematory or other place)

Crest Lawn Memorial 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3-3-99 Marriottsville, Md. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Haight Funeral Home & Chapel Paige Häight Herbert Box 195 Sykesville, Md. 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Ceuse (Final 6 months disease or condition resulting in death) Examiner Examiner physician end the buriel-trensit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceusa. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consaquance of): 9 esn signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? Covonary Artery disease 1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware eutopsy findings eveileble prior to completion of ceuse of death? Dia betes inellitus Completed 24a. Was an autopsy page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate f or Attending Physician: effer death. Director: After this certifice funeral director, 25. Wes cese referred to medicel examinar? 26. Place of Deeth (Check only one) Othar: 4 Nursing Homa 5 Residence 6 NOther (Specify) Hospite Hospital: 0 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 Naturel 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and Jitle of certifier 29c. Licensa number MArch 1,1799 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) N. Charles St. Balts. Md 2,200 6BMC Riley 6701 32. Registrer's Signeture 31. Date filed (Month, Day, Year) Registrar

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	2 Date of Death	2	Time of	0
Certificate of Death	Reg. No.	UU	32 0	-
State of Maryland / Department of Health and	Mental Hygiene	00	NE	5

Physician /Medical Examiner

Earl Douglas Fisher

Funeral

Director the Marylend r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health end Mentei Hygiene. Important: if them 27 is marked other than "natural", or thes any injury or other traumatic event, the Medical Exempt

Baltimore, Maryland 21215-0020

Examiner physician end the burial-transit certificate be executed Box 68760 for ed by the a P.O. signed by t Division of Vital Records, has certificate funeral director, this After death. after death Director:

1. Decedent's Nama (First, Middla, Last) Death Month 7:45 A.M. Douglas Fischer. Earl II 4b. City, Town, or Location of Death 1999 4c. County of Deeth 4a Facility Nema (If not institution, giva street and number) Peninsula Regional Medical Center Salisbury Wicomico If Undar 1 Year If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yaar) May 8, 198 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) Months Days Min. 1 M 2 F Hours 219-06-0892 17 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Somerset Maryland Eden 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 14236 Carver Manor Circle 21822 USA Funeral 12. Was Decadant Evar in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Rece - American Indien. Black, White, etc. 1 ☐ Yas 2 No If Yas, Giva Yaer or Dates: 1€ Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Student High School 11 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Be Earl Douglas Fischer Angela Brown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Earl D. Fischer/Father 14236 Carver Manor Circle, Eden, Md. 21822 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State Buriel 2 ☐ Cremetion 3 ☐ Ramovel from Stata 3/5/99 Eden, Maryland Zion Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvica Licensee 22. Nama and Addrass of Facility Hinman Funeral Home Princess Anne, Md. 2 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21853 Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final diseesa or condition rasulting in death) Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaase or Injury that Initialed avants rasulting in daath) Last Dua to (or as a consequence of): an/Medical Dua to (or as a consequance of): Physici Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara autopsy findings aveilable prior to complation of ceusa of daath? 24a. Was an autopsy performad? Completed 1 Nos 2 No 2 No 25. Was casa rafarred to medical axaminar?

↑ Yas 2 No Be 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of tnjury "Month, Day Year) 28d. Dascribe how Injury occurred 27. Mannar of Death 28b. Tima of 28c. injury at Work? 1 Natural 2 Accident Injury 1 olk 5 Panding ch 366198 1 ☐ Yas 445 AX1 Invastigation 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, ferm, straat, factory, offica building, atc. (Specify) 4 Homicida roodway to 1 Certifying Physictan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marker as state 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Cartifiar Medical (Check only one) 29b. Signetura end title of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) ~~ O.C.M.E. March 03, 1999 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Registrar

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32/Registrar's Signatura

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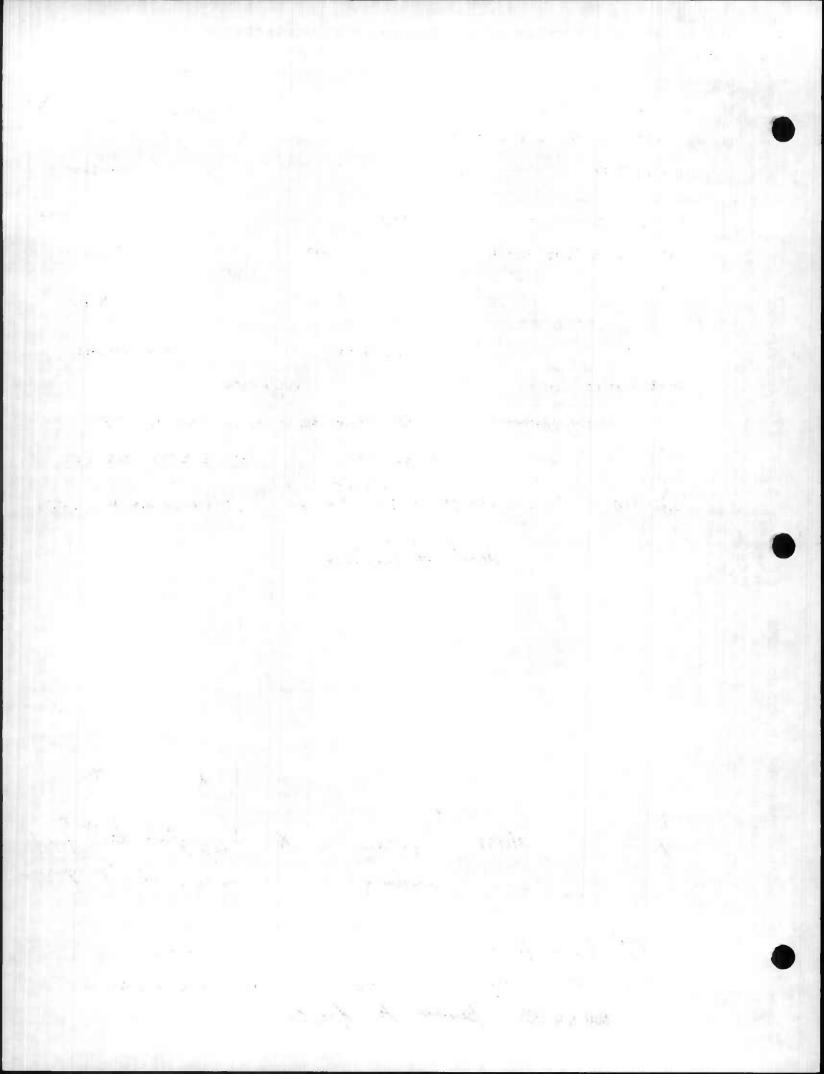
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State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent'e Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Day Physician Mary Ida Ford March 4, 1999 4:10 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Home Frederick Frederick If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) June 22, 1910 5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar 9. Birthplace (Stata or Foreign **Funeral** Days 1 M 2 F Months Hours Country) Maryland Director 88 578-30-1918 Usuel Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yas 2 No Director Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Nems 23a or 21703 United States 1316 Apple Tree Court Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No 11. Meritel Status 14. Race - Amarican Indian, Black, Whita, atc filed within 72 hours after. Hygiene. other than "natural", or the 1 Nevar Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ♥ No Specify: If Yas, Giva Yaar or Datas: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Own Homemaker 8th Pages 1 and 2 should be filed value to Health end Mental Hygients if Nem 27 le marked other t 18. Mothar's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Be Henson Chase Eliza Washington 19a. fnformant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Joseph Moses Ford, husband 1316 Apple Tree Court Frederick, Maryland 21703 20b. Place of Disposition (Neme of cematery, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from Stata Important: I any injury o 3/5/99 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 21. Signature of Funeral Service License 22. Nama and Addrass of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702 Approximata fntarval Between Onset and Death Do not antar tha moda of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediete Cause (Firla diseese or condition resulting in death) Examiner Examiner burial-transit that the deeth certificate be executed Sequentially list conditions, if any, laeding to immadiata causa. Enter Undarlying Cause (Diseese or injury that initiated events rasulting in death) Last and Dua to (of as a consequance of attending physician for use as the buria Box 68760 Physiclan/Medical Due to (or es a consequance of) 85 P.O. per per Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 30 No 3 Probably 4 Unknown Records, à 24b. Wara autopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Was an autopsy has No No 1 Yas 1 Yas certificate Division of Vital or Attending Physician: director. 25. Was case rafarred to medical 26. Place of Death (Check only one) 1 Yas 2 No Other: Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 1 Inpetient 2 ER/Outpetient 3 DOA this 28a. Data of fnjury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of After 5 Pending invastigation Natural 1 ☐ Yas 2 ☐ No death. 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifian 29c. License number red cause of death (Item 23a) (Type, Print) Registray's Signature

State Registrar

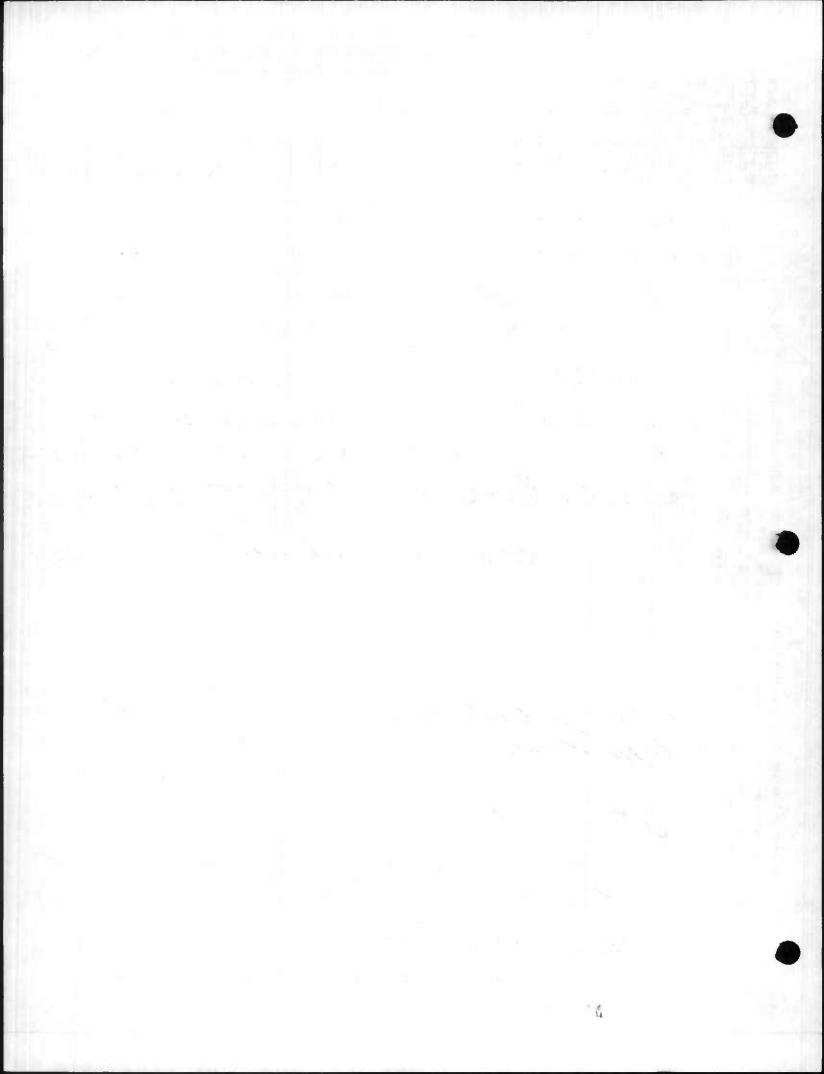
DHMH 16 Rev 6/95

1999

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ^Day</sup>999 March 4, 0310 FOGLE Martha /Medical 4a. Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 5. Social Sacurity Number 214-10-1332 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Sept. 25, 1918 **Funeral** 1 □ M 2 X F Months Days Yrs. Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Frederick Maryland Frederick 14 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 6 West 12th Street U.S.A. Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No if Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Bleck, White, etc. 11. Marital Status filed within 72 hours efter 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed with Department of Health and Mental Hygien, Important: If Item 27 is merited other that any Injury or other trainment. Public School System Secretery 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Malden Surneme) Be Dorsev S. Culler Jane Ranneberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 916 Pine Avenue, Frederick, Maryland 21701 David A. Fogle/Son 20b. Placa of Disposition (Name of cameters, cremators or other placa)
Mt. Olivet Cemetery 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 XBurial 2 Cremation 3 Removal from Stata March 8, 1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licanses 22. Name and Address of Facility
Keeney & Basford Funeral Home M00021 106 East Church St., Frederick, MD 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betw **Physician** /Medical Immediete Cause (Fine disease or condition resulting in death) Examiner Examiner physician and s the buriaf-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) ettending p Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by t 3 Probably 4 Unknown 1 Tyes 2 No Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was case referred to medical 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred Medical Certification: 28b. Time of 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 5, 1999 D30496 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Francis E. Becker, M.D., 300 West Ninth Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 0 8 1999 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

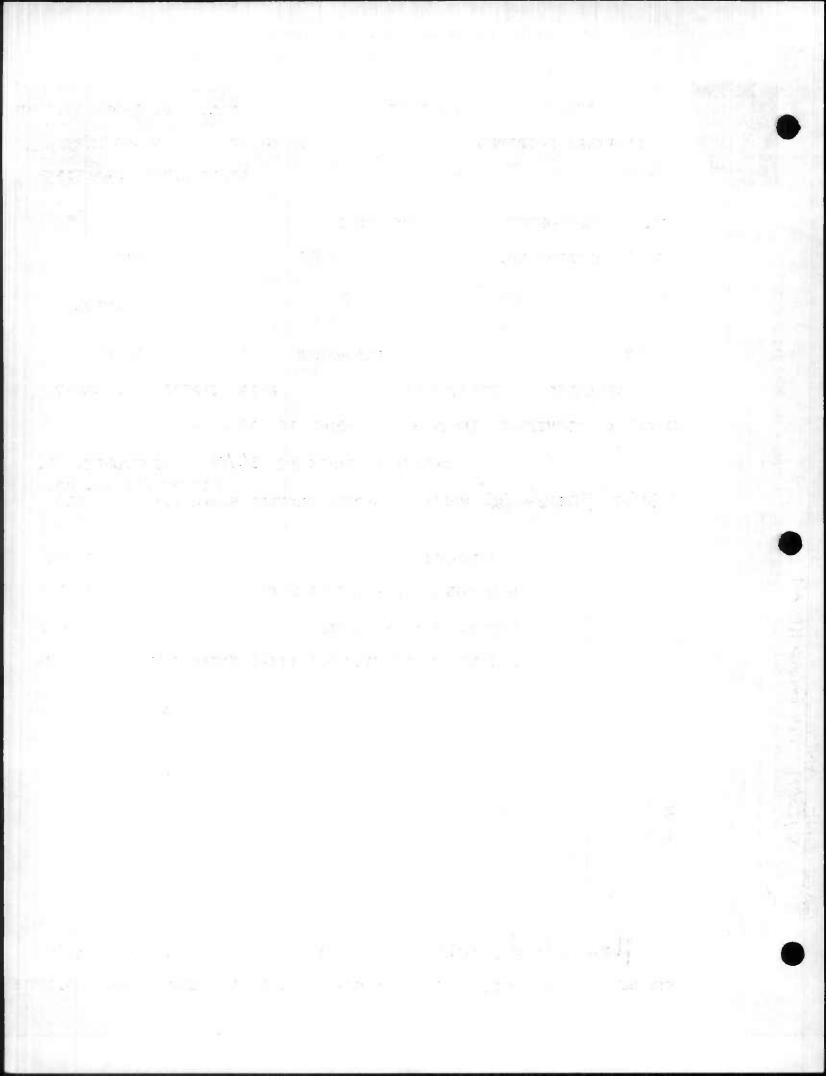
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth **Physician** Month GAGLIONE ANGELE 1999 FEB. 26, 11:10AM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. Cltv. Town, or Location of Deeth 4c. County of Death Examiner SUBURBAN HOSPITAL MONTGOMERY BETHESDA 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (Stete or Foreign **Funeral** 1 M 2 N F Months Deys ALGERIA Yrs. Director NONE 95 Usuel Residence of Decedent tha Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Exprement must be notified at 1 Yes 2 No Director MONTGOMERY BETHESDA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7105 MARBURY RD. 20817 FRANCE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: 11. Maritel Stetus Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 XNo Specify: by Specify: 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Peges 1 and 2 should be filed withit Department of Health and Mantal Hygiene. Important: If flem 27 is marked other than any injury or other trauments. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) VINCENZO BRANCACCTO MARTA GRAZIA HONARATO 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIMONE C. PLUVINAGE/DAUGHTER ITEM #10 SAME 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from State 3/1/99 4 ☐ Donetion 5 ☐ Other (Specify) CHAMBERS CREMATORY RIVERDALE, MD. 21. Signeture of Funerel Service Limited 22. Name end Address of Facility SILVER SPRING, MD. 20910 M00091 CHAMBERS FUNERAL HOMES, P.A. 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) SEPTICEMIA 1 DAY Examiner Due to (or es e consequence of): ABDOMINAL AND PELVIC ABSCESES 3 DAYS Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): PERFORATION OF RECTUM 4 DAYS Physician/Medical 8 Due to (or es e consequenca of) 7 DAYS RECTAL OBSTRUCTION AND FECAL IMPACTION Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? B 1 Yes 2 No 3 Probably 4 Unknown þ 9 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical Be 26. Plece of Deeth (Check only one) examiner? Hospitel: 1 XInpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To # 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Atter 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 | Homicide hours 29a. Certifier 1 🔀 Certifying Physictan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. To the Hor within 24 h To the Fur 2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, death occurred et the time, dete end placa, end due to the ceuse(s) end menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DIMINE omas FEB. 26, 1999 D35110 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) THOMAS G. ZORC, 5530 WISCONSIN AVE., #1455, CHEVY CHASE, MD. 20815 M.D. 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

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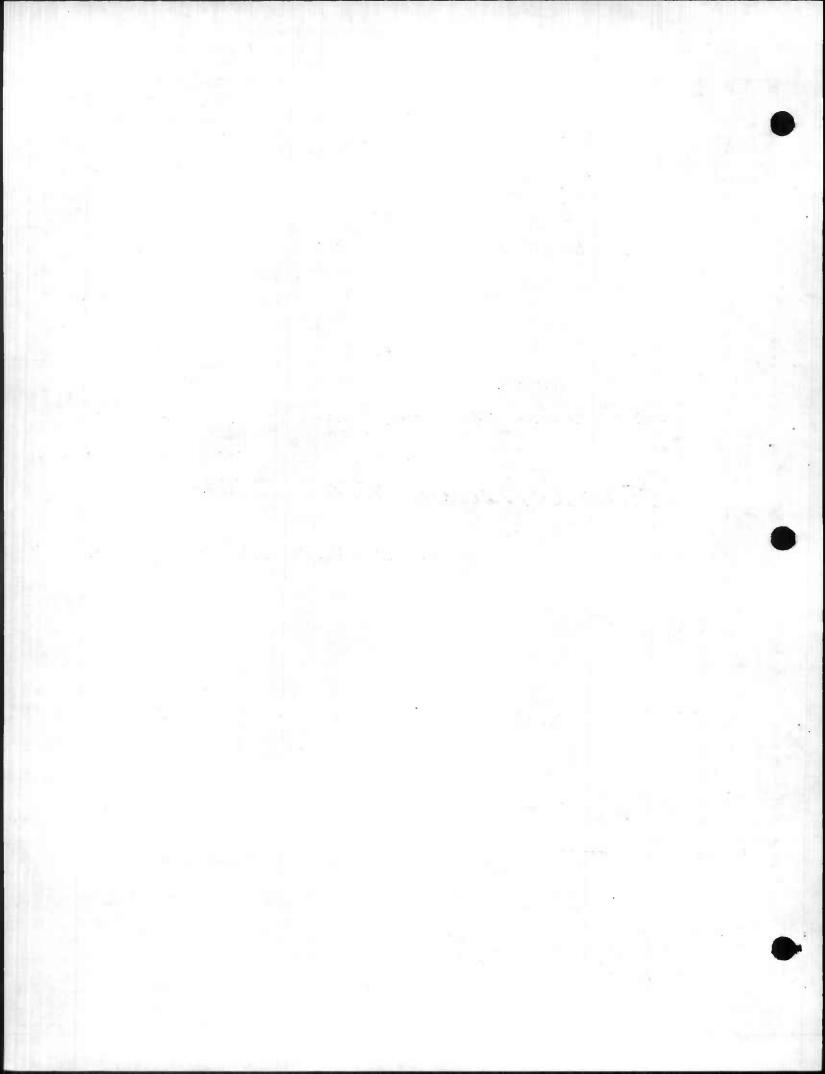
Staltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene

		oldio or mary.c	Ce	rtificate of	Death		eg. No.	8462	
Physician	1. Decedent's Name (First, Middle, La					2. Date of Deat Month		3. Time of Death	
/Medical	WILLIAM	F. GASSA	WAY			MARCH	2, 1999	1:15 AM	
Examiner	4a Facility Name (If not institution, giv		W-3 C	lantan	4b. City, Town, or L		4c. County of Dear	th	
W	University of 5. Social Security Number 6. S		Med. C		Baltin		O Div	Abulana (Cinta au Faraina	
Funeral Director		2 F 7. Age (m)		Months Days		B. Date of Birth (Month, Day, Year) June 3,1942 9. Birthplaca (Stata or Foreign Country) Maryland			
M M	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits	
and and and and and and and and and and	MD Montgo	mery	De	rwood				1Ã Yes 2□No	
ath with the Maryla 23s or 28s-f shor unit be notified at rai Director	10e. Street and Number 17622 Horizon	Place		10f. Zip Code 2 0	855	1	10g. Citizen of What Country? U.S.A.		
020 urs atter des if, or items Examiner in by Fune	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	U,S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, atc. Specify: Black		
5-0 72 hg	15. Decedeni's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occu	pation during most of work id)	ina	16b. Kind of Business	/Industry	
2 E . E . D	Elementary/Secondary (0-12)	College (1-4or 5+)				,9	City of Rockvil	10	
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land id be file ental Hy kad othe ic event o Be C	Frank W. Ga					el Fraz			
Mary 12 should 12 should 15 mars 15 mars 16 mars 17	19a. Informant's Name/Relationship (19b. Mail	ing Address (Stree	t and Number or Rui	al Route Number	City or Town, State,	Zip Code)	
2551	Carol Ann Gass	away (Wife) 176	22 Hori	zon Plac	ce, Der	wood, MD	20855	
altimore, mit. Papes 1 ur partment of Hea portant: If Nem? y Injury or othe	20a. Method of Disposition	PREDOVALITORI STATE		osition (Name of omatory or other planed Grove C		Date 3/6/99	20c. Location - City or Laytons	Town, State Ville, MD	
pemit. Departrimporta any inja	21. Signatured Funeral Sarvice Licenter	Mow	Hou 2	2. Name and AddreSNOWDEN ROCKVII	ess of Facility FUNERAL	L HOME,	P.A.		
	23a. Part1. Enter the divase, or com shock, or heart lawre. List only	dications that caused the de	eath. Do not en				est,	Approximate Interval Between	
Physician	O. C. C. C.			~ I.		10		Onset and Death	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	1)1/0	Ted (jardi	OMUGI	bath 4	/	72 WONTHS	
	resuming in death)	Due to	(or as a conse		1				
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68760, filtate be associted physicien and as the bunal-trensit edical Examir	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initialed events	Due to	(or as a conse	quance of):				1	
68760, ficate be ay physicien is the burie	Cause (Disease or Injury that initialed events resulting in death) Last	C Due to	(or as a conse	quenca ol):				1	
- O 6	Tosoning in doubly East	a .							
BOX 6 leath certification attending 1 for use as		d							
P.O. BOX nat the death cent of by the attendin letached for use Physician/N	Part II. Other eignificant conditions of	ontributing to death but not r	esulting in the I	underlying cause gi	ven in Part I.	23b. Did to	bacco use contribute	e to the cause of death?	
Cords, P.O. v requires that the de been signed by the should be detached leted by Physic	Acute ou	Chronic	Ken	ial ta	lure	1 🗆 Y	s 25 No 3□P	robebly 4 Unknown	
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He to the						1 🗆 Ye	es 2 00	1 Yes 2 No	
Vital Iclan: T iclan:	25. Was case referred to medical examiner?				26. Placa of Dear	th (Check only on	ne)		
P == 0	1 Yas 25 No		☐ ER/Outpatie	nt 3LI DOA		ome 5 Raside	enca 6 Other (Spe	ecity)	
DIVISION OF VITA I or Attanding Physician: after deeth. Director: After this certific of in by the funerel director, ertification: To Be (27. Magner of Death Watural 5 Pending Invastigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	Wo	ry at ork?] Yes 2 □ No	28d. Describe ho	ow injury occurred		
DIVISION C ball or Attending P is after deeth. at Director: Aftert led in by the tuners Certification:	3 Suicide 6 Could not be determined	28a. Place of Injury - Al building, atc. (Spe		28f. Location (St City or Town	reet and Number or R n, Stata)	urat Route Number,			
Hospitu 24 hours Funers tely fille	29a. Certifier Check only one) Certifying Physics Medical Exert	ysician: To the best of my k liner: On the basis of exami and manner stated.	nowledga, deat nation and/or Ir	th occurred at the ti	ima, data and place, opinion, daath occur	and dua to tha cored at tha time, d	ause(s) and mannar a ata and place, and du	s stated. a to tha cause(s)	
within 2 To the comple	29b. Signature and Mile of certifier	PM 1	Λ	29c Licen	se number	. 2	9d. Date signed (Mon	th, Day, Year)	
16	I Pelly XTN	W. Yllan. M.K).	AUIII	76435 E	1004	3/2/	99	
(3	30 Name and address of person who	completed cause of death (In	em 23aj (Type	Print)	int Mor	1 Ctr.	Patt. 1	10	
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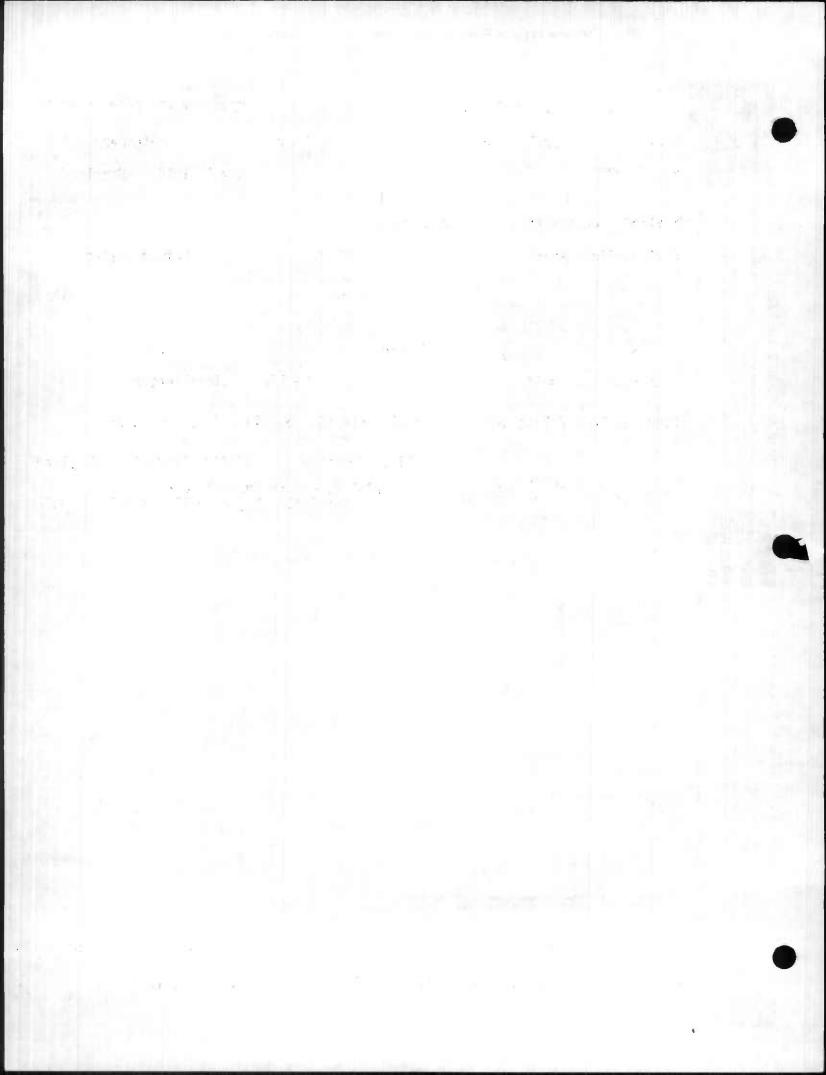
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene \(\)

			Cer	tificate of	Death		F	Reg. No.		
	1. Decedent's Name (First, Middle,	Last)					Date of Dea	ath Day	Year	3. Time of Death
Physician /Medical	RUBY I	1. GEISBERT				FÉ	BRUAR	RY 27 1	999	9:47 AM
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	Montgomery Gene	eral Hospital			01ney			Montg	omer	у
Funeral	5. Social Security Number 6	· Die opte	s. lest birthday)	If Under 1 Year Months Days		Min. 8. C	Date of Birth Month, Day	h v. Year)	9. Birthp	iece (State or Foreign
Director	214-78-2771	1□ M 2,83 F 82	Yrs.			Ma	y 14	1916		y1and
	Usuel Residence of Decedent 10e. State 10b. County	100	Dia Taura anta							04 1 14 00 11 1
el, or items 23a or 28a-f show Examiner must be notified at by Funeral Director			City, Town or Lo						'	0d. inside City Limits 1 ☐ Yes 2 ☑ No
Be-f	Maryland Montgor	mery Ga	aithers	_						
or 28a-f e be notified Director	10e. Street and Number			10f. Zip Code				10g. Citizen of V		
23a	6920 Warfield Ro	oad		2088				United	State	es
r Items 234 Ther must Funeral	11. Maritel Status	12. Wes Decedent Ever in Armed Forces?	U,S. 13. \	Vas Decedent of f Yes, specify Cub	Hispenic Orlg can, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)	14. Rac Blac	a - Americ k, White,	
F. F.	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		I Yes 25 No				Specify		White
edical Examination	3 Midowed 4 □ Divorced	Year or Dates:								
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E SE	19a. Informant's Name/Relationship			ng Address (Stree						Code)
be .	Donna L. Webb /			Route 9					21797	
or othe	20a. Method of Disposition 1. ■ Buriel 2 □ Cremetion 3	DRemovel from State	 Place of Dispo cemetery, cren 	sition (Name of netory or other ple	ece)	De	ete	20c. Location -	City or To	wn, State
2	4 Donetion 5 Other (Spe		t. Olive	et Cemet	ery	3/3	/99	Frederi	ck,	Maryland
any injury or one	21. Signature of Funerel Service Li	censee// //		. Name end Addr						
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	23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caused the de	eth. Do not ent	er the mode of dy	ing, such es d	cardiac or res	piretory er	rest,	ryia	Approximate
cian	shock, or heart failure. List or	nly one cause on each line.							i	Interval Between Onset and Death
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eteched for us Physician	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause o	iven in Part I		23b. Did 1	inhacco usa co	ntribute to	the cause of death?
deteched for	Tartii. Ottor alginiicani conditioni	s contributing to coath but not n	esuming in the un	nderlying cause g	worring and i.		1 🗆 '	_/		bably 4 Unknown
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To Be	1 ✓ Yes 2 ☐ No 27. Manne of Death	1 Inpatient 2	28b. Time of	I 3LI DOA	4 □ Nur	-		dence 6 Oth		ý)
lon o	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey Year)	injury	W	ork? ☐Yes 2☐↑		Describer	10W IIIJuly Occur	160	
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pletely fill	(Check only 2 Medical E)	Physician: To the best of my k aminer: On the basis of exami								
completely filled in by the Medical Certific	20b Signature and title of continer	end menner stated.		20e Lies	nea number			29d. Date signe	d (Manth	Day Yearl
8	29b. Signature and title of certifier	las MD			nse number			Contract to		
	Magazina	NID		104	3358			FEBRU	ARY	28,1999
	V	no completed cause of death (It								
		AGAYA DAN,				CE OF	RCHA	RD BLV	D, G	AITHERSBUR
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Spore						MD 2087
Registrar	MAR 02	1999 Denew	19.	Spark	61					

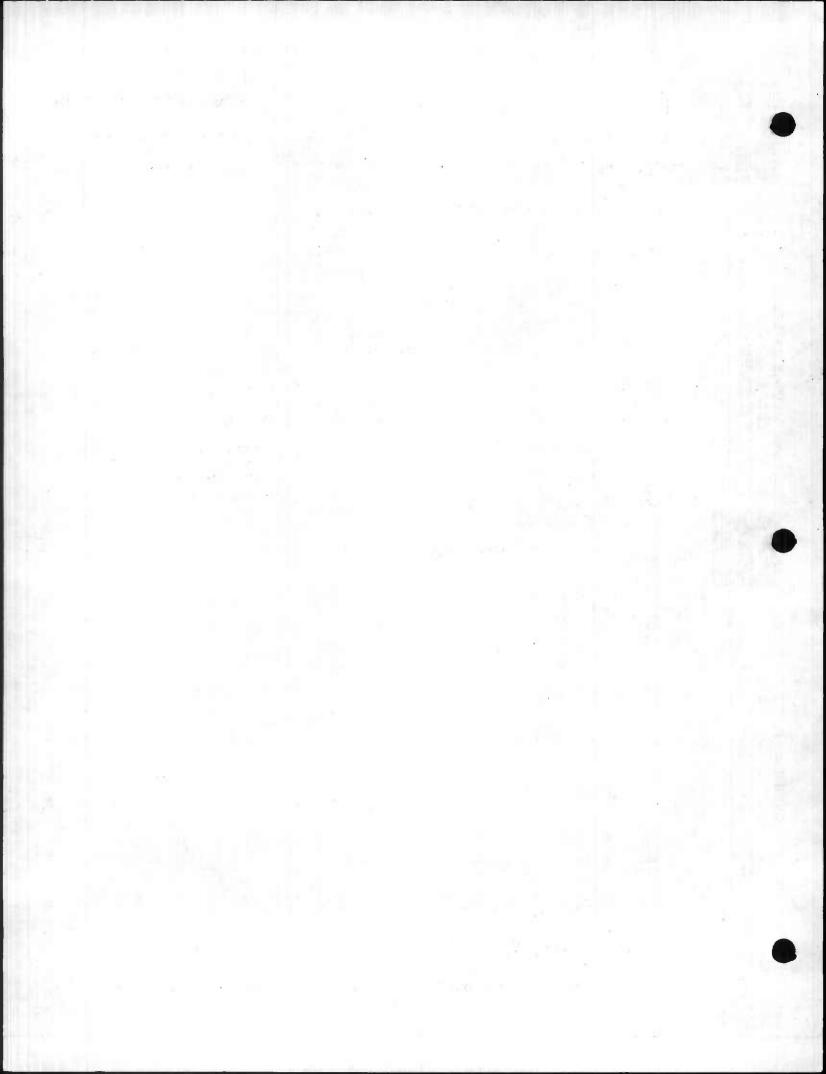
DHMH 16 Rev 6/95



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	1. Dece	dent'e Name (First, Middle,								Date of Dea Month	th ry 28,1	de de la company		ne of Death
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iner		ility Name (# not institution, 816 Whetstone		oer)				Montgome			4c. County	gome	r37	
al				Age (In yrs.	. last birthday)		1 Year	If Under 24 Hr	-	Date of Birth (Month, Day				ate or Foreign
or		-22-5894	1∏M 2□F	6	6 Yrs.	Months	Days	Hours Mir	n. ((Month, Day Sept.	11,1932	Penn	nsyl	vania
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Director		reet and Number	Drive			10f. Ziq	Code 208	86			Og. Citizen of V		-	
Funeral	11. Mar	ital Status	12. Was Deced		J,S. 13. V	Was Dece	dent of Hi	ispanic Origin? (n, Mexican, Pue	Specif	y Yes or No-		e - Amaric	an India	n,
ò	3□	Never Married 2∏ Marrie Widowed 4 □ Divorced	Armed Ford 1 🖾 Yes 2 If Yes, Give Year or Dat	□No 19.	57 - 75	f Yes, spe		n, Mexican, Pue Specify:	irto Ric	an, etc.)	Specify	k, White, Wh	etc. Lite	
Completed		15. Decedent's (Specify only highest	Education completed		16a. Deced	ient's Usu	al Occupi	ation	ndkina		16b. Kind of Bu	usiness/Inc	lustry	
hple	Elem	entary/Secondary (0-12)	College (1-4	lor 5+)				during most of w	UIKIII		TT C			
	17 Fatt	anda Nama (First Middle I	4		LL.	Col.	USA		//	innt Afields	U.S.		orc	5
To Be	На	ner's Name (First, Middle, Li rry Goch				15		Mary	Kal	pella	Maiden Suman			
		formant's Name/Relationshi en Goch (Wi	p <i>(Type, Print)</i> ife)					end Number or A						386
		ethod of Disposition		20b. i	Place of Dispo- cemetery, cren	sition (Na	me of other plac	e)		Date r. 10	20c. Location -	City or To	wn, Stat	0
		Burial 2 ☐ Cremation 3 ☐ Other (Spe			lington					999	Arling	ton,	Va.	
4	21. Sig	nature of Funeral Service Li	censee		22	. Name a	nd Addres	s of Facility I	eVo	ol Fun	eral Ho	me		70 -30
		Curtes &	· Ley			10 E	ast I	Deer Par	Dı	. Gai	thersbu	rg, M	ld.	20877
niner 1	disease	iate Cause (Final e or condition g in death)	a. Recurr		xtensiv or as a conseq			Small Ce	211	Lung	Cancer		15	month:
Examiner	Sequer if any, I cause.	ntially list conditions, eading to immediate Enter Underlying		Due to (or as a conseq	uence of)								
Ca	that init	(Disease or injury liated events g in death) Last	C	Due to (d	or as a conseq	uence of):						t		
-			d									i		
-	resultin	Wher elgnificant condition	d.	th but not res	ulting in the ur	ndertvina	cause cive	en in Part I.		23b. Dld t	obacco usa co	ntribute to	the ca	see of death?
Physician/Medi	resultin	Other algnificant condition	ds contributing to dea	th but not res	sulting in the ur	nderlying (cause give	en in Part I.			obacco use co			uee of death?
by Physician/Medi	resultin	Other significant condition	d	th but not res	sulting in the u	nderlying (cause give	en in Part I.	-	101	7ee 2□ No	3 Prol	ere auto	4 Unknow
by Physician/Medi	resultin	Other algorificant condition	ds contributing to dea	th but not res	sulting in the u	nderlying o	cause give	en in Part I.		1 🗆 Y	ree 2□ No an autopsy med?	3K) Prol 24b. We ave con	ere auto ailable p mpletior death?	4 Unknow
Completed by Physician/Medi	Part II. (s case referred to medical	ds contributing to dea	th but not res	sulting in the u	nderlying o	cause give	en in Part I. 26. Place of D	eath (1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ree 2 No an autopsymed? Yes 2 No	3K) Prol 24b. We ave con	ere auto ailable p mpletior death?	4 Unknown
Be Completed by Physician/Medi	Part II. (Mossitali		sulting in the ur		Oth	26. Place of D		24a. Was a performance of the Check only of the Check on	ree 2 No an autopsymed? Yes 2 No	3 Prol 24b. We ave co of	pably ere auto ailable p mpletior death? Yes	4 Unknown
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edical Certification: To Be Completed by Physician/Medi	25. Wa. 9xa 1 27. Mar 1 1 2 3 4 2 29a. Cd (Cd a 29b. Signature)	s case referred to medicat miner? Yes 2 No mer of Death Natural 5 Pending investiga Accident Could no determin I Certifying pheck only ne) Medical Exp	Hospital: 1 In In In It In In It In In It In In It In In It In In It In It In It In It In It In It In In It In In In In In In In In In In In In In	patient 2 [Injury Day Year) I tnjury - At h., etc. (Special set of my known is of examinar stated.	28b. Time of Injury loome, farm, stri	M eet, factor	OA Othorse Injury World 1 y, office at the tim	26. Place of D er: 4 Nursing / at / 7 Yes 2 No na, data and place pinion, death occurs a number	286 286 286	24a. Was a performance of the pe	ree 2 No an autopsy med? res 2 No ne) ence 6 Oth ow injury occur ittreet and Numb n, State) causa(s) and me fate and place,	24b. We ave conditions of the average of the averag	pably pere auto allable p mpletior death? Yes Ves Ves Value Day, Ye	4 Unknown psy findings rior to a of cause 2 No Number,
edical Certification: To Be Completed by Physician/Medi	25. Wa. 9xa 1 27. Mar 1 2 2 3 4 2 29a. Cd (Cd a) 29b. Signature 2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	s case referred to medical miner? Yes 2 No ner of Death Natural 5 Pending investiga Accident Could no determin	Hospital: 1 In In In It In In It In In It In In It In In It In In It In It In It In It In It In It In In It In In It In In It In In In In In In In In In In In In In	patient 2 [Injury Day Year) I tnjury - At h., etc. (Special est of my known is of examinar stated. Moof death (tter	Der/Outpatien 28b. Time of Injury In	M eet, factor cocurred restigation	OA Othorse Injuny World 1 y, office at the tim, in my of the RESC	26. Place of D er: 4 Nursing / at / 7 Yes 2 No na, data and place pinion, death occurs a number	Home 286 286 286 ce, and curred	24a. Was a performance of the control of the contro	ree 2 □ No an autopsy med? res 2 □ No ne) ence 6 □ Oth ow injury occur street and Numb causa(s) and me fate and place, 29d. Date signe March 1	24b. We ave conditions of a superior of Rura anner as stand due to d (Month, 199)	pably pere auto allable p mpletior death? Yes Ves Ves Value Day, Ye	4 Unknown psy findings rior to a of cause 2 No Number,

DHMH 16 Rev 6/95

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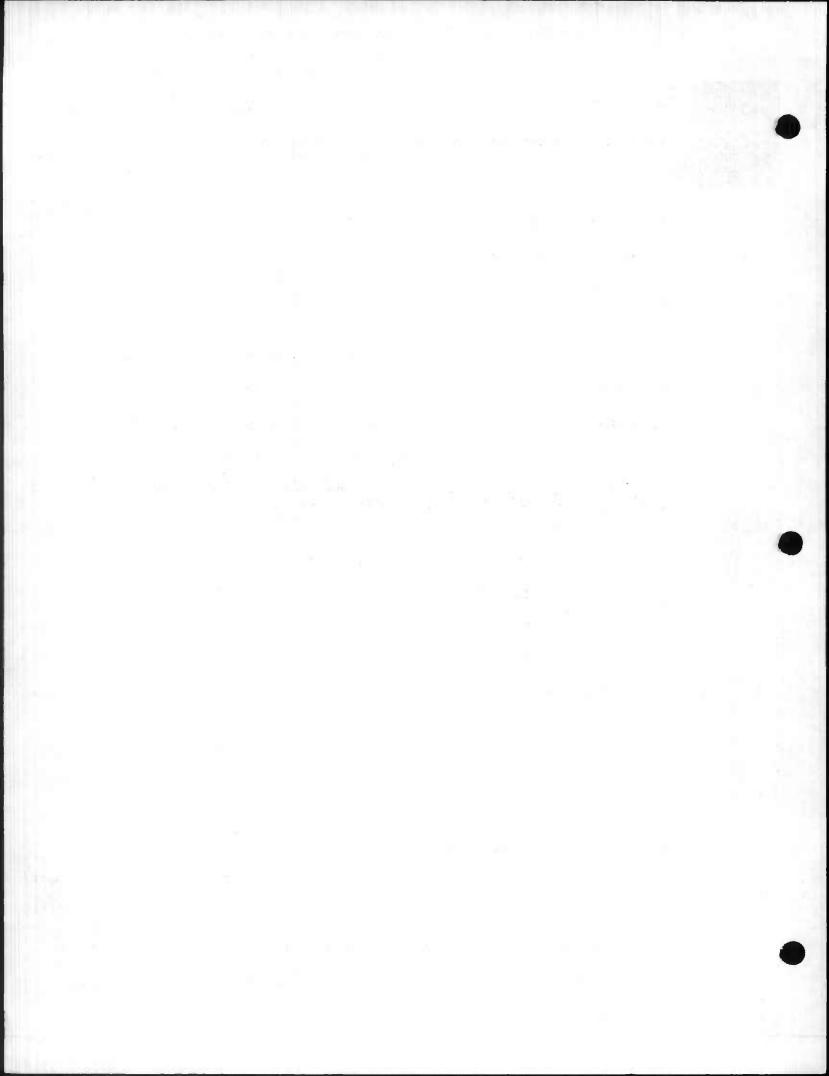


State of Maryland / Department of Health and Mental Hygiene 99

						Ce	ertifica	te of	Death			Reg. N	lo.			
4		1. Decedent's Name (First, Mid	dle, Las	t)							2. Dete of De	eth		Vas	3. Time	of Death
Physicia /Medic		Sara Perry G	ordo	n							March		1999	Yaar	2115	,
Examine		4a. Facility Nama (If not institut	ion, give	street end numb	er)				4b. City, To	wn, or L	ocation of Deat	-	c. County	of Deeth		
		Shady Grove	Adv	entist	Hosp	ital			Rock	vil	le MD		Mon	tgome	ery	
Funeral Director		5. Sociel Sacurity Number 323-40-9164 Usuel Residence of Decedent	6. Se	9x 7. □ M 2ဩ F	Age (In yrs.	lest birthdaj Yrs.	/) If Unda Months		If Undar Hours	24 Hrs. Min.	8. Date of Bin (Month, De Feb. 28	rth By, Yea B,]	910	9. Birthpla Countr Illin	ce (Stete y) Ois	e or Foreign
ž ==	ł	10e. Stete 10b, Coun	ty		10c. Cit	y, Town or I	ocation							100	d. Inside	City Limits
lifted a	ctor	MD Mont	gome	ry	Мо	ntgom	ery V	illa	ge							s 2⊠No
23a or 20	ai Director	10e. Street and Numbar 19310 Clubhou	se F	d., Apt.	609		10f. Zi	Code 208	86			10g. C	itizen of \USA	What Countr	y?	
- 1	by Funeral	11. Marital Status 1 Never Married 2 Mi 3 XWidowad 4 Divorce		12. Was Decede Armed Force 1 Yes 2 If Yes, Give Yaer or Date	s? ¿No	S. 13	Wes Dece If Yes, spe 1 Yes	cify Cut	oen, Mexica	n, Puarto	pecify Yes or No Ricen, etc.)	>-		e - America ck, White, et v: W		
alcal alcal	ted	15. Decede (Specify only high	ent's Ed	ucation		16a. Dec	edent's Usu	el Occu	petion	t of work	ring	16b.	Kind of B	usiness/Indu	stry	
other than "natur vent, the Medical	Completed	Elementary/Secondery (0-12		College (1-4d	or 5+)				during mos			Fd	ucati	l on		
the ut	S	17. Fether's Neme (First, Middle	a. Last)	JT		seco	ndary	SCII	T		e (First, Middla	1				
arked o	o Be	Tilden D. Per	. ,								Mills			ď		
is marked aumetic e	F	19e. Informent's Neme/Relation		vpe. Print)		19b. Mai	ling Addres	s (Stree			ral Route Numb	er. City	or Town.	State. Zip C	Code)	
tam 27 is marked othe other traumatic event,		Karl H. Gordo									urchton				,	
tem	1	20a. Method of Disposition			20b. P	laca of Disp	osition (Ne	me of		, 011	Dete			City or Tow	n, Stata	
7 0		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other			te	t Poi			,	13	3/6/99	We	st P	oint,	TI.	
important: If itam 27 is any injury or other tra		21. Signeture of Feneral Sarvice			VIN.	·	22. Name e Home ,	nd Addr Inc	9	Un:	rancis iversit 20901					1
ling physicla	in/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	{	e Pulr	Due to (o	emol emol res e conse	equence of)	ne	ism ck	A	ractu	re		d	ini ays	utes
the atte	sicia	Pert II. Other significant condi	lons co	ntributing to death	but not resi	uiting In the	underlying	cause g	ivan In Pert	 I.	23b. Dld	tobacc	o use co	ntribute to t	he caus	e of death?
A D	Phy										10	Yes	2 No	3 Probe	ibly 4	Unknown
	Completed by										24e. Wes	en eul ormed?	opsy	com	e eutops: labla prio pletion of eeth?	or to
page 2	E										10	Vac	2 No	10	1	DNO
certificate rector, pag		25. Wes case referred to medic	ai						26 Piace	of Dee	th (Check only		چڪون		143 21	200
10 TO	0	examiner? 1 Yes 2 No		Hospitel: 1 Inpe	atient 2	ER/Outpatio	ent 3 D	OA OI	her:		ome 5 Resi		6 □Oth	er (Specify)		
는 교	2	27. Menner of Deeth		28e. Dete of li		28b. Tima		28c. Inju			28d. Describe					
the fune	Certification:	1 Naturel 5 Penc 2 Accidant inves 3 Suicide 6 Coul	tigation	February	1 28,1919	2:40	P. M.	1	Yes 2	No	Fall					
d in by the	ert		mined	28e. Place of building,	Injury - At ho	ome, farm, s	treet, fector	y, offica			28f. Location (wn. Sta	te) .	010	Ulan	Lund MI
iner ly fill	edicai C			elclan: To the besing and manner	of exeminal							ceuse		enner es ste		V
To the Fa		29b. Signature end title of certif	ier L.	Toms,	Roj T	mD	29	c. Licen	se number	6		29d. D	ate signe	g (Month, D	199	19
		30. Name end eddress of person Patriod L. 7	DM5	ko, MD,	11140	Roci	Print) //e	Pi	ke,#	348,	Rocki	ille	M	D 21	085	Q
Stat	Α .	 Dete filed (Month, Dey, Yea 	7)	/ 32. Regi	strar's Signe	ture	1			/		/				

DHMH 16 Rev 6/95

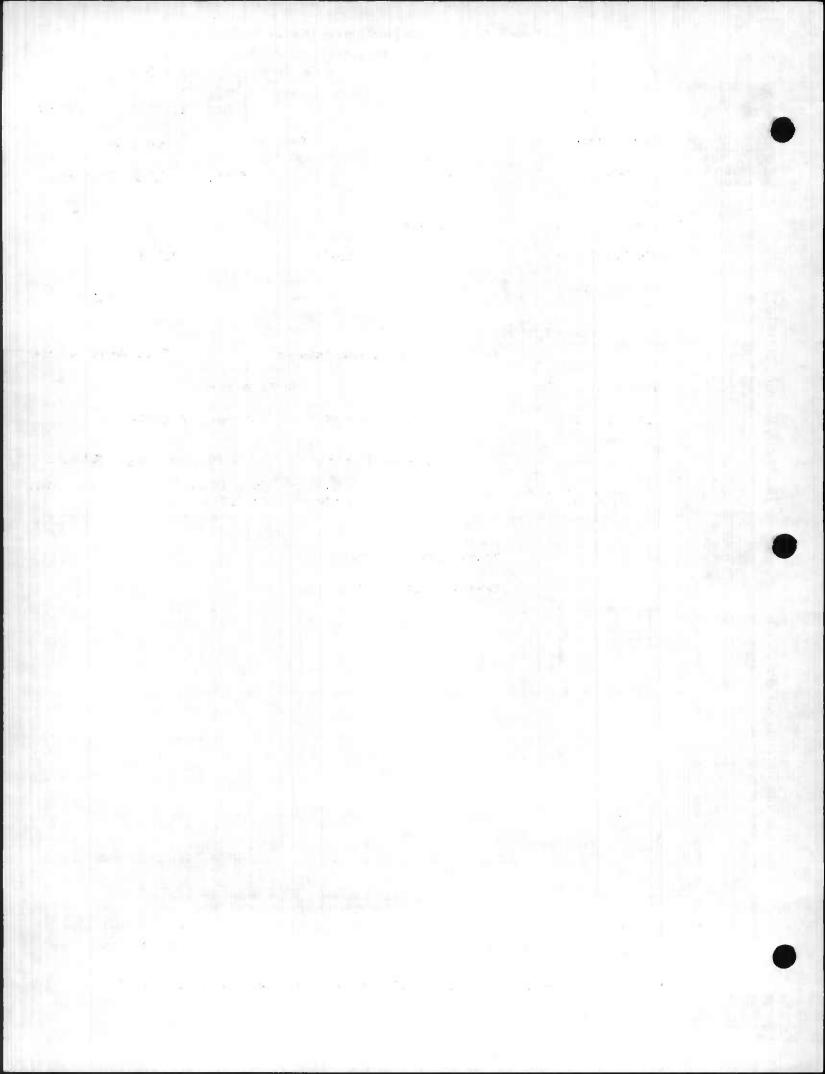
State Registrar



State of Maryland / Department of Health and Mental Hygiene O

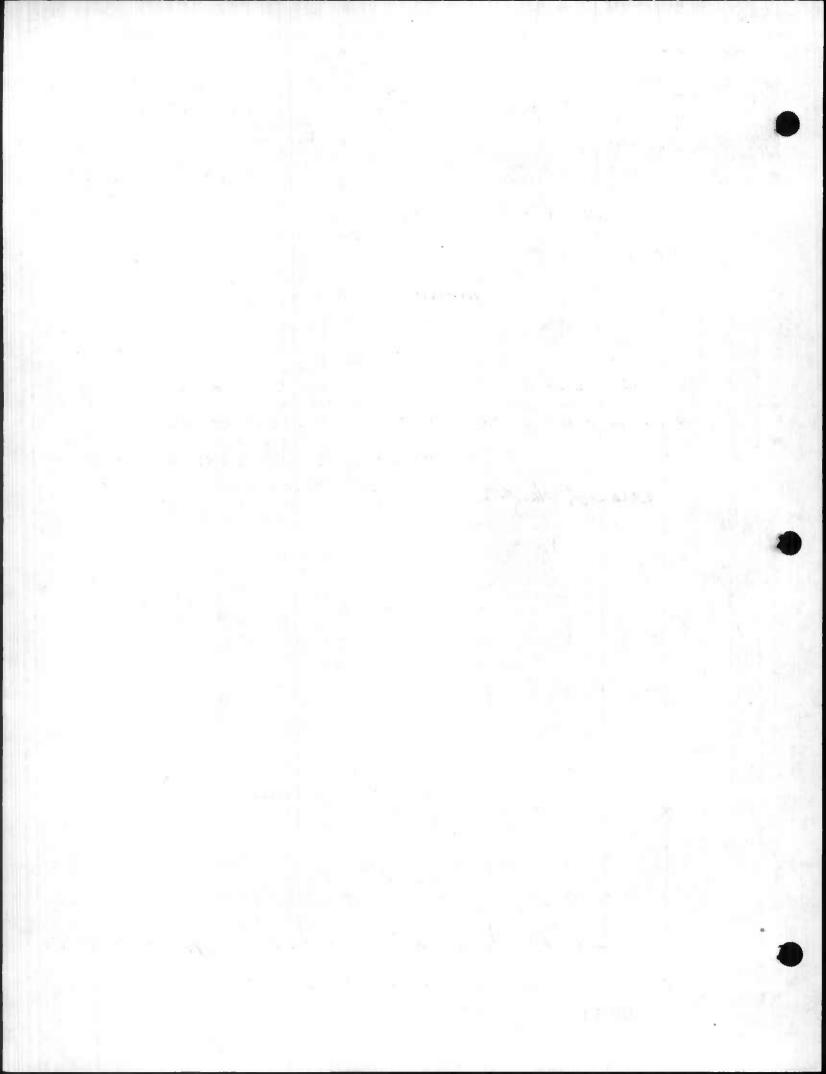
	A Constant Name (First A			Certificate of			Reg. No.	00	3. Time of Death
Physician	1. Decedent's Name (First, No. 2011) Donald C.					Month	Dey 26, 1999	Year	7:00PM
/Medical Examiner	4a Facility Name (If not instit		ber)		4b. City, Town, or I				7:00FF
Examiner	10520 Stable				Potomac		Monte	omerv	
Funeral Director	5. Social Security Number 508-01-2421	6. Sax 7. 1 X M 2 □ F	. Age (In yrs. last b	irthday) If Under 1 Yea Months Day:		8. Date of Birt (Month, De)	h y, Year)	9. Birthplac Country	ce (Stete or Foreign
	Usuel Residence of Deceden	ıt	19			sept. Z	8, 1919	Nebi	aska
show	10a. Stete 10b. Co		10c. City, To	vn or Location				10d.	. Inside City Limits 1X Yas 2 □ No
he M	Maryland Mon	ntgomery	Poto	omac 10f. Zip Code			10g. Citizen of V	That Country	250
Mith I	10520 Stable	Lane		2085			U.S.A	mer country	
podification of the Mary Maria Maria Mary Section of the Mary and Department of Health and Maria Mygiene. Department of Health and Mental Mygiene. In proportion of the marked other than "naturel", or freme 23a or 28a-f show any injury or other traumatic event, in a Maria Exercise must be mental and page. To Be Completed by Funeral Director	11. Marital Status 1 Never Merried 2	If Yas, Giva	es?	13. Was Decedant of If Yas, specify Cu	Hispanic Origin? (S ban, Mexican, Puart	pecify Yas or No- o Rican, atc.)		- American k, Whita, atc	2.
thours e	3 ☐ Widowad 4 ☐ Divo	rcad Yaar or Date		a. Decedent's Usual Occ	upation		16b. Kind of Bu		
led within 72 ho tygiene. Then neture it, it worked	(Specify only his	ighest grede completed)		(Give kind of work don life. DO NOT use retir	a during most of wor	king			
Nom the	Elementary Coolingary (o	5+	101017	Asst. Commi				Gover	nment
Me file	17. Father's Nama (First, Mid				18. Mother's Nan			Θ)	
d Menid to marke	Garold C 19e. Informant's Name/Relat		10	b. Mailing Address (Stre		Burches		State Zin C	ode)
Mich en 27 le r traur	Mary Jane-			.0520 Stable					JO6)
Dallillore, Maryland ZIZIS-UUZU Demit. Peges 1 end 2 should be filed within 72 hours ef Department of Health end Mentel Hygiene. Important: if item 27 le marked other trans-naturel; or may hipury or other traumatic event, in the Medical Examination. To Be Completed by F	20a. Method of Disposition 1 Buriel 2 Cremat 4 Donetion 5 Othe	ion 3 X Removal from St	ate	of Disposition (Nama of ery, crematory or other p view Cemete:		Dete 3/2/99	20c. Location -	0.00	
Departing Importal any Injure once.	21. Signature of Funeral Sen	vice Licensee			ress of Facility Wiler's So		, 5130 W	iscons	sin Ave.
	23a. Part1 Enta diseas	e, or complications that cau	used the death. Do		-		rrest,	A	pproximete
fifcete be executed so the burial-transit edical Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	о	Due to (or as a neral Art	Infarction a consequence of): cerioscleros consequence of):	sis				
net the deeth certificate be one the deeth certificate be deeth dey the attending physicies telesched for use as the burn Physician/Medical I	resulting in deeth) Lest	d	Due to (or as a	consequence of):					
deeth deeth	Part ii. Other significant con	ditions contributing to dea	th but not resulting	in the underlying cause	given in Part i.	23b. Dld	tobacco use co	ntribute to ti	he cause of death
						10	Yes 2□ No	3 Proba	bly 4∭ Unknow
The law requires that the law requires that the set has been signed by the page 2 should be deteched.							en autopsy med?	evaile	e autopsy findings able prior to pletion of cause eth?
The I						10	Yes 2 No	10	Yes 2□ No
ysiclen: The k girector, page fo Be Com	25. Was case referred to me examiner?					ath (Check only o	one)		
Physician: rthis certific and director,	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 🗆 In		dipatient 30 DOA		lome 5 Resident	dence 6 Oth		
trending death. ctor: After y the fune	1 Natural 5 Per 2 Accident inv	ending (Month) restigation ould not be	f Injury - At home,	Injury W	☐ Yes 2☐No		Street and Numb		Poute Number,
To the Hospital or A within 24 hours after To the Funerel Direct completely filled in b Medical Certif	29a. Certifier 🛣 Cert	ifying Physician: To the b				e, and due to the	cause(s) and ma		
the H thin 24 the F mplete	one)	and manne			nsa number		29d. Data signe		
2 3 2	29b. Signeture and title of ce	Dard	wn-	D161			Feb. 28		
	30. Name and address of per				o Ct D-	1+imo==	MD 212	Q 7	
Chaha	Norman And		DUI NO gistrer's Signature	rth Carolin		тстшоге,	rm ZIZ	07	
State Registrar	MAR 0	2 1999	energe	B. Span	69				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		I. No. 00 001, 67
Physic		1. Decedent's Name (First, Middle, Last) GARRY CHARLES GICK	2. Dete of Deeth Month	Day Yeer 3. Time of Dee 128 1999 1727
/Medi Exami			VI, or Location of Deeth	4c. County of Deeth
		UNIVERSITY OF MARYLAND MEDICAL SYSTEM BA	LTIMORE	Baltimore City
Funeral Director		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 1 Under 1 Year If Under 2 Hours 23 Yrs.	Min. (Month, Dey, Y	(ear) 9. Birthpiece (Stete or For Country)
		Usuel Residence of Decedent	Oct. 8,	1975 Maryland
4 show	ō	10e. Stete 10b. County 10c. City, Town or Location Marriottsville		10d. inside City Lir 1 ☐ Yes 2X
or 28a-	irect	10e. Street end Number 10f. Zlp Code	10g	. Citizen of Whet Country?
23a	rai	7721 Ridge Road 21104		U.S.A.
s i and 2 should be filed within 72 hours effer death with the Merylend fe Heelth and Mental Hygiene. The February 27 is marked other than "natural", or frems 23a or 28a-f show other traumatic event, the Medical Examinet must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married A 3 Wildowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 12. Wes Decedent Ever in U,S. If Yes, specify Cuben, Mexican, If Yes, Give 1994 - 1998 12. Wes Decedent Ever in U,S. If Yes, specify Cuben, Mexican, If Yes, Give 1994 - 1998 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Original In Yes, Specify Cuben, Mexican, If Yes, Specify Cuben, If Y	In? (Specify Yes or No- Puerto Rican, etc.)	14. Rece - American indian, Biack, White, etc. Specify: White
"natural",		15. Decedent's Education 16e. Decedent's Usual Occupation	16	b. Kind of Business/Industry
e. an "n	Completed	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 16e. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	
Nental Hygiene. Mental Hygiene. arked other than stic event, the	S	12 Marine		U.S. Military
d oth	Be	17. Fether's Neme (First, Middle, Last) 18. Mother	's Neme (First, Middle, Mei	
nd Men	2		Christina Le	
h and h and ls me traum		19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number) 19c. Name/Reletionship (Type, Print) 19c. Name/Reletionship (Type, Print) 19c. Name/Reletionship (Type, Print)		
Heelth am 27 ther tr		Mr. & Mrs. Donald Gick (Parents) 7721 Ridge Road, 20e. Method of Disposition (Name of		LLe, MD 21104 c. Location - City or Town, Stete
0 0		1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Crestlawn Memorial Gard		
Department Important: It any Injury o		21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility	1	
RSE S S		Brian L. Glantz HAIGHT FUNERAL	HOME & CHAPE	L (Box 195)
_		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart feilure. List only one cause on each line.	cardiac or respiretory errest	Approximete Intervel Between
hysician		Shoot, or hoot locate. Elst only one bease on each line.		Onset end Deetl
/Medical xaminer		immediate Ceuse (Finel disease or condition resulting in death) e. EXSANGUINATING HE mo	RRHAGE	3 HOURS
Xammer	L	resulting in death) e. Due to (or, es e consequence of):		
s is	ine	LIVER LACERATIONS	4	Lact 3 HOUR
physician end s the burial-transit	Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	FICATION APPROVED BY MED	CAL EXAMINER
Sician		Ceuse. Enter Underlying Ceuse (Disease or injury thet Initieted events C	THE PROVED BY MED	No.
ng phy es the	edic	resulting in deeth) Lest Due to (or es e consequence of): CERTI	FICATION AF	
e attending physician end	M	d		
attendin d for use	Physician/Medical	Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.	22h Didtaha	and the general de
igned by the a	hys	The street arguments conditions contributing to death but not resulting in the underlying cause given in Pert 1.	1□ Yee	acco use contribute to the cause of dec 2 No 3 □ Probably 4 □ Unkr
ate has been signed by the	by P			210 110 0 1 1 1 0 0 1 1 0 1 1 1 1 1 1 1
an sig			24a. Wes en e	eutopsy 24b. Were eutopsy findin
s been 2 shoul	Completed		performed	d? eveileble prior to completion of cause of deeth?
te has	Eo		1 ☐ Yes	2 No 1 Yes 2 No
	0	25. Was cese referred to medicel 26. Plece	of Deeth (Check only one)	***
0 0	To B	examiner?	sing Home 5 ☐ Residence	e 6 □Other (Specify)
h. After thi funeral		27. Menner of Death 28e. Dete of Injury 28b. Time of 28c. Injury et	28d. Describe how	88 88
death. ctor: Af y the fur	Certification:	1 Neturel 5 Pending (Month, Dey Yeer) Injury Work? 2 Accident Investigation Feb. 28, 1999 1:54 PM 1 Yes 2	10 MOTOR VE	HICLE ACCIDENT
	tiffic	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street	et end Number or Rurel Route Number, SteteLiberty Rd. Near
s effer al Direct ed in by	Cer	STREET		a., Balto., MD
within 24 hours effer To the Funeral Dire completely filled in b	edicai	29a. Certifier (Check only one) Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deet end manner stated	place, and due to the caus	se(s) and menner as stated
within 24 hours To the Funeral completely filled	₩ W	one) end menner steted. 29b. Signature end title of certifier 29c. License number	294	. Dete signed (Month, Day, Yeer)
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		1 71-101	L /V	larch 3 1999
		30. Name end eddress of person who completed of use of deeth (Item 23e) (Type, Print)	2	AIRNIZZI
		FRANK K. JONES, MD 22 SOUTH GREENE STREE	T IJALTIMOR	E, MUZIZOI
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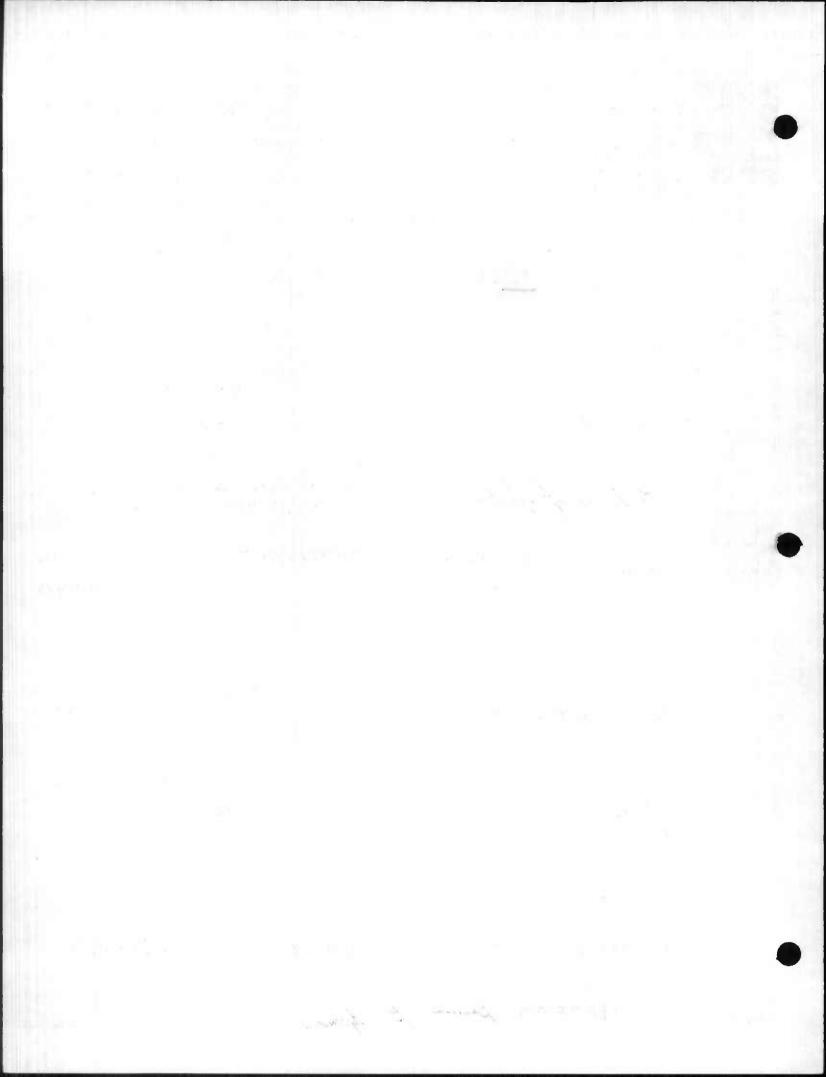
Amended #12, 03/03/99, TM, Kent Co. State of Maryland / Department of Health and Mental Hygiene Co. Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** February 25, 1999 Clifford Gell 8:00 a.m. /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27370 Morgnec Road (Residence) Chestertown Kent 6. Sex 12 M 2□ F 7. Aga (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs.

Months Days Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplace (State or Foraign Country) **Funeral** Months Days Hours Yrs. Director 80 217-36-2142 December 12, 1918 Mary Del, MD Usual Residance of Dacedan death with the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, Its Medical Examiner must be notified at 1 Yes 2 No Director Marvland Kent Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 27370 Morgnec Road 21620 USA 12. Was Decedent Ever in U.S. Armed Forcas?

Wyos 2 M No if Yes, Giva Yaar or Datas: 14. Race - American Indien, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any Injury or other traumatic event. It a mental is a 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No White Specify: þ 3 Widowed 4 Divorced Completed Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Elementary/Secondery (0-12) Collega (1-4or 5+) Food Industry Maintenance 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Surnama) Joseph Gsell Mary Elizabeth Faulkner 19a. Intermant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) Ruth A. Gsell/Wife 27370 Morgnec Road, Chestertown, MD 21620 20b. Placa of Disposition (Nema of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1XX Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Spacify) Chester Cemetery 2/28/99 Chestertown, MD 22. Nama end Addrass of Facility 21. Signetura of Junarai Sarvice Licanse Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part . Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart tailura. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** . ISCHEMIC CARDIONYOPATHY /Medical Immediate Causa (Final 76 mo disaesa or condition rasulting In daath) Examiner Dua to (or es e consequança ot) Examiner 7 5 Y 15 ATHERUSCIERUSIS the buriel-transit Sequentially list conditions, if eny, laading to immedieta causa. Entar Underlying Ceusa (Disaasa or Injury thet initiated avants rasulting In daath) Last Dua to (or as e consaquanca of) pue Box 68760. Physician/Medical Due to (or as a consequence of): Records. P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed by ADRIC STENOSIS 24b. Wara autopsy tindings available prior to Completed 24a. Was an autopsy complation of cause of deeth? certificate hes 1 □ Yas AKNo 1 □ Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

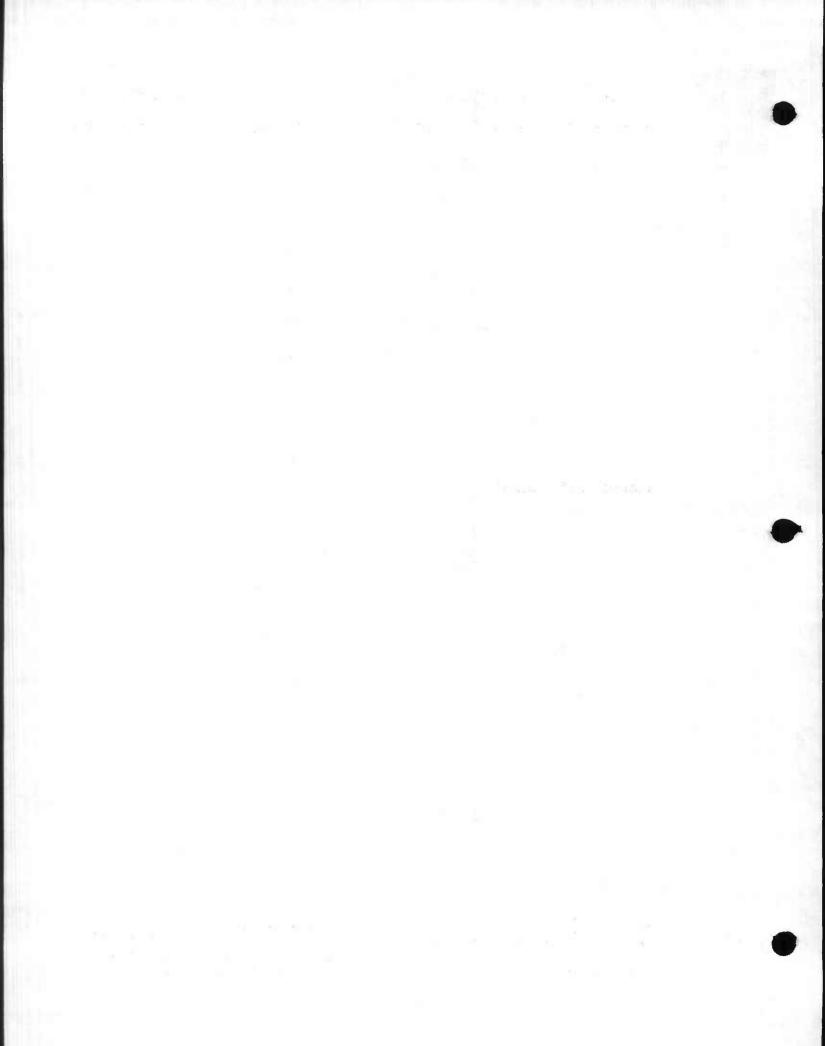
To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was casa ratarrad to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home Residance 6 Othar (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpetlent 3 DOA 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Natural 5 Panding 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 3 Suicida 6 Could not be determined Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, tarm, street, factory, offica building, atc. (Specify) 4 Homicida 1 Actifying Phyalcian: To the best of my knowledga, daath occurred at the time, dete and place, and dua to the cause(s) and mannar as stetad.
2 Medicat Examiner: On the basis of axemination end/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end mannar stated. 29e. Certifian Medical 29b. Signatura and titla of certifie 29c. Licansa number 29d. Date signed (Month, Day, Year) 6 30. Name end addrass of person who completed cause of death (Itam 23e) (Type, Print) Helen A. Noble, 122 Speer Road, Suite 5, Chestertown, MD 21620 32. Ragistrar's Signatura 31. Data filed (Month, Day, Yaar) State FEB 26 Spark Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene (

						tificate		Death		Reg. No.	2 10	0.9	69
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Aerylend I show	٥	Usual Rasidance of Decedant 10a. Stata 10b. County Md. Montg	omery		y, Town or Lo						1		de City Limits
3a or 28a-	Funeral Director	10e. Street and Number 11644 Drumcast1	e Terrace			10f. Zip C		20876			of Whet Cour		
ore, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours efter death with the Meryland of Health and Meriel Hygiene. Item 27 is marked other than "naturel", or items 23a or 23a-f show other traumstic event, the Mexical Examiner must be notified at	Š	11. Marital Status 1 Navar Merried 2 X Merried 3 Widowed 4 Divorced	12. Was Decedan Armed Forces 1 □ XYas 2 □ If Yas, Giva Year or Dates	19°	74- '	Vas Decedar f Yas, specify		lispenic Origin? (S an, Mexican, Puert Specify:	pecify Yas or No o Rican, etc.)		Rece - Americ Biack, Whita, ectly: B1		n,
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Baltimore, M permit. Peges 1 and 2 Department of Health of Important: if them 27 is any injury or other tra		1 ☐ Burial 2 💢 Cremation 3 4 ☐ Donetion 5 ☐ Othar (Spe	city)		lace of Dispo ematary, crem ropoli	tan C	cem	atory	Feb. 27, 1999	Alexa	on-City or To		
Ban permit		21. Signature of Funarel Sacrice Lie	Day					oss of Fecility De Deer Park				Md.	20877
Physiclar /Medica Examine	i r	23a. Part1. Entar tha disease, or conshock, or haart failura. List or Immediata Causa (Final diseasa or condition resulting in death)		ONARY	ARTER	Y DISE			or raspiratory a	rrest,		Approx Interva Onsat	ilmata I Between and Death
Box 68760, eeth certificate be executed attending physician and ifor use as the burial-trensit	in/Medical Examiner	Sequentially list conditions, if eny, laading to immadiate cause. Enter Undardying Causa (Disaese or Injury thet initieted evants rasuiting in death) Last	b		r es e conseq								
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0 4 4 5		27. Mannar of Death 1 2 Natural 5 Panding 2 Accidant invastigat	28a. Date of inj (Month, D		28b. Tima of Injury		. Injui		28d. Dascribe			<i>y</i> /	
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State of Maryland / Department of Health and Mental Hygiene

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£,	Funeral Director		5. Sociel Security Number 6. Sa 245-20-6076 Usuel Residence of Decedent	X 7. Age	e (In yrs. lest bii 73	Yrs.	Months Deys		8. Dete of Birth (Month, Det FEB. 28	Year) 1925	Count	laca (State try) CAROL	or Foreign
land	No to		10e. State 10b. County		10c. City, Tow	n or Loca	ation				10	0d. Inside (City Limits
Man	18	to	MD. PRINCE	GEORGES			RIVERDA	LE.				1 🎇 Ye	s 2□No
h the	7.28	Director	10e. Street and Number				10f. Zip Code	,		10g. Citizan of V	Whet Count	try?	
iw d	23a c	aiD	5301 TAYLOR	RD.				20737		ī	J.S.A.		
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mit. Pages 1			20a. Method of Disposition	Communi from Ctata	20b. Place o cemete.	f Disposit	tion (Neme of story or other pl	ece)	Dete	20c. Location -	City or Tov	wn, Stete	
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tai or An	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.		4 Homicide determined	28e. Plece of Injubuilding, etc	. (Specify)				28f. Location (S City or Tow	m, Stete)			n <i>ber</i> ,
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Registrar

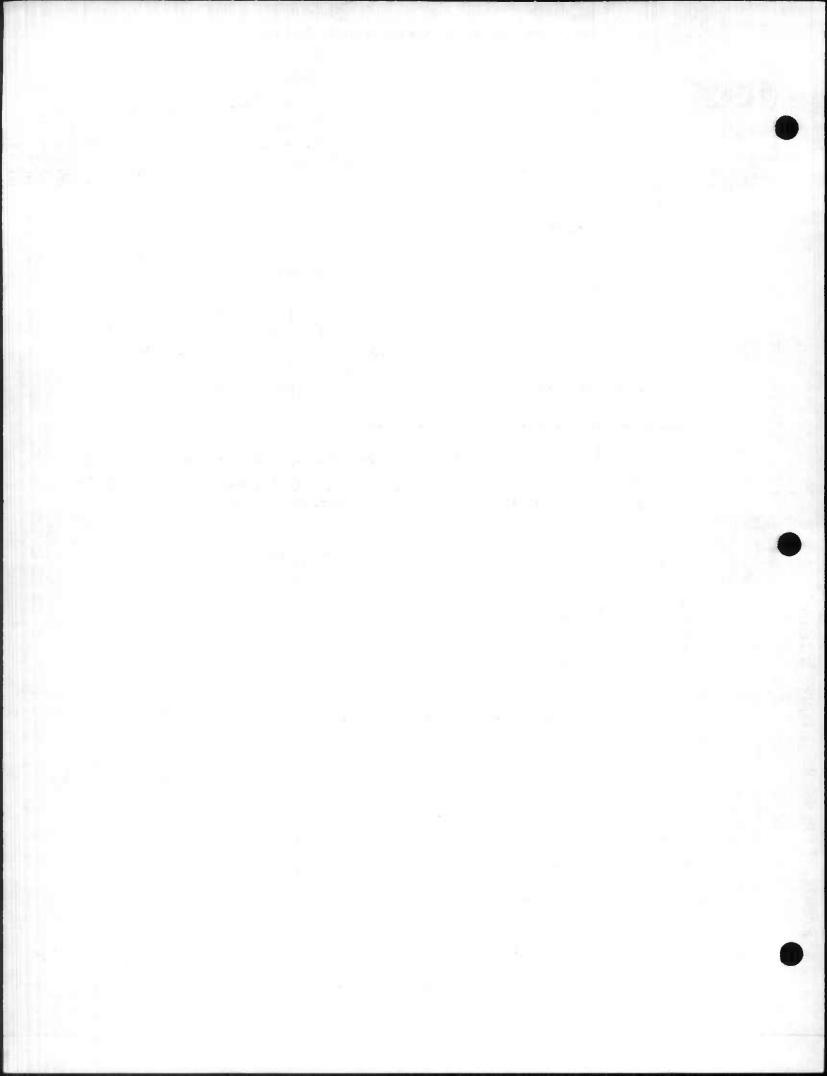
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State of Maryland / Department of Health and Mental Hygiene

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/Medica		Evelyn Rita Ho	ıser						Februar	y 27, 1	999	1326
Examine		4a. Facility Nama (If not institution	, giva street and numb	er)			1	4b. City, Town, or	Location of Daatl	4c. County	of Death	
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ahow	20	10a. Stata 10b. County			ity, Town or						10d	. Insida City Llmi
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8 9	吉	10e. Street and Number				10f. Z	ip Coda			10g. Citizen of 1	What Country	17
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natu	Completed	15. Decedent (Specify only highes	's Education t grada complated)		16a. De	cedent's Us	uai Occup	eation during most of wo	rkina	16b. Kind of B	usiness/Indus	stry
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Aent rkad tice	10	Maurice Col	lins					Irene	Connely			
pud .		19a. Informant's Name/Ralations	ip (Type, Print)		19b. Ma	ailing Addra	ss (Street	and Number or R	ural Routa Numb	er, City or Town,	Stata, Zip Co	ode)
r tra		Elizabeth A. K	ennev/Daugi	hter	14 F	aith	Cour	t, Damas	cus. MD	20872		
Health Hem 27 I		20a. Method of Disposition		20b.	Placa of Dis	position (N	ama of		Data	20c. Location	City or Town	n, Stata
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the land	8	oney	and mannar	statad.								
100	Σ	29b. Signature and title of certifier	> -			2	9c. Licans	a number		29d. Data signe	d (Month, Da	y, Year)
_			ele	MO		7	033	443		Felma	ry 27	7, 1999
		30. Name and address of person of Algn R Pollack	ho completed causa of	809	m 23a) (Typ	e, Print)	1.11	a number 443 ed	Rockui	le, ma	208	51
State	100	31. Data filed (Month, Day, Yaar)	32. Ragi	strar's Sign	ature							

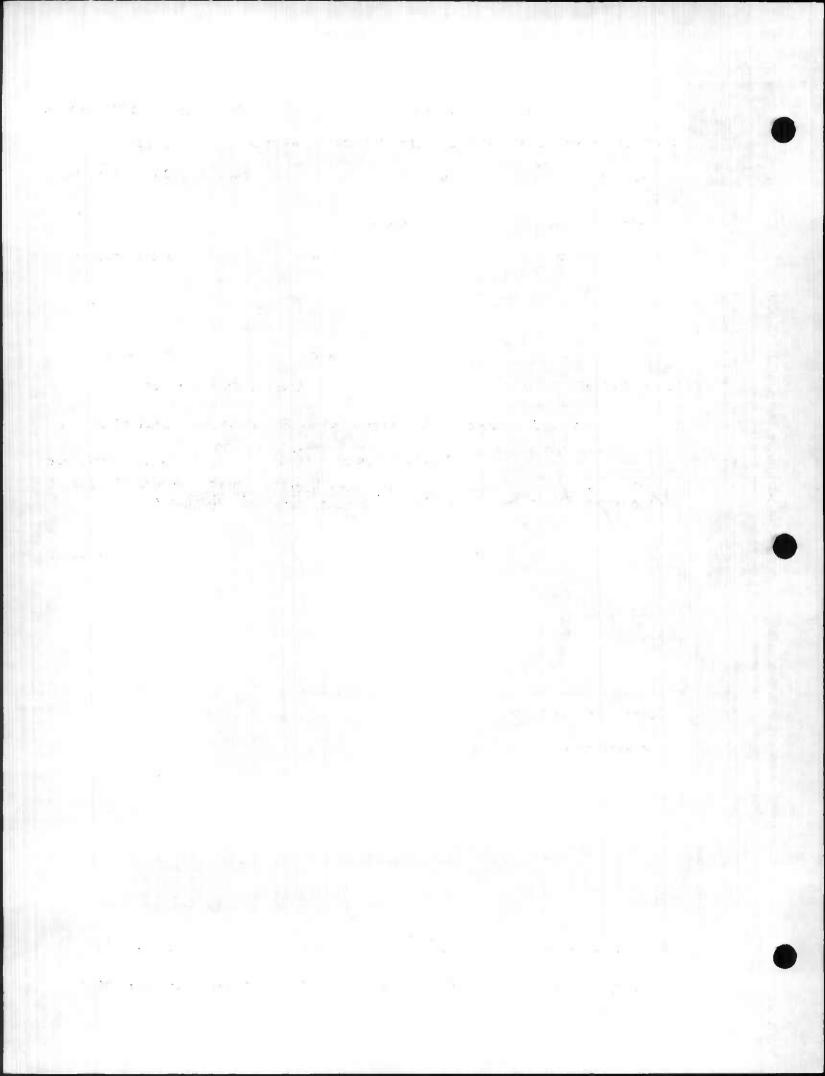
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EVELYN R. HOUSER



State of Maryland / Department of Health and Mental Hygiene

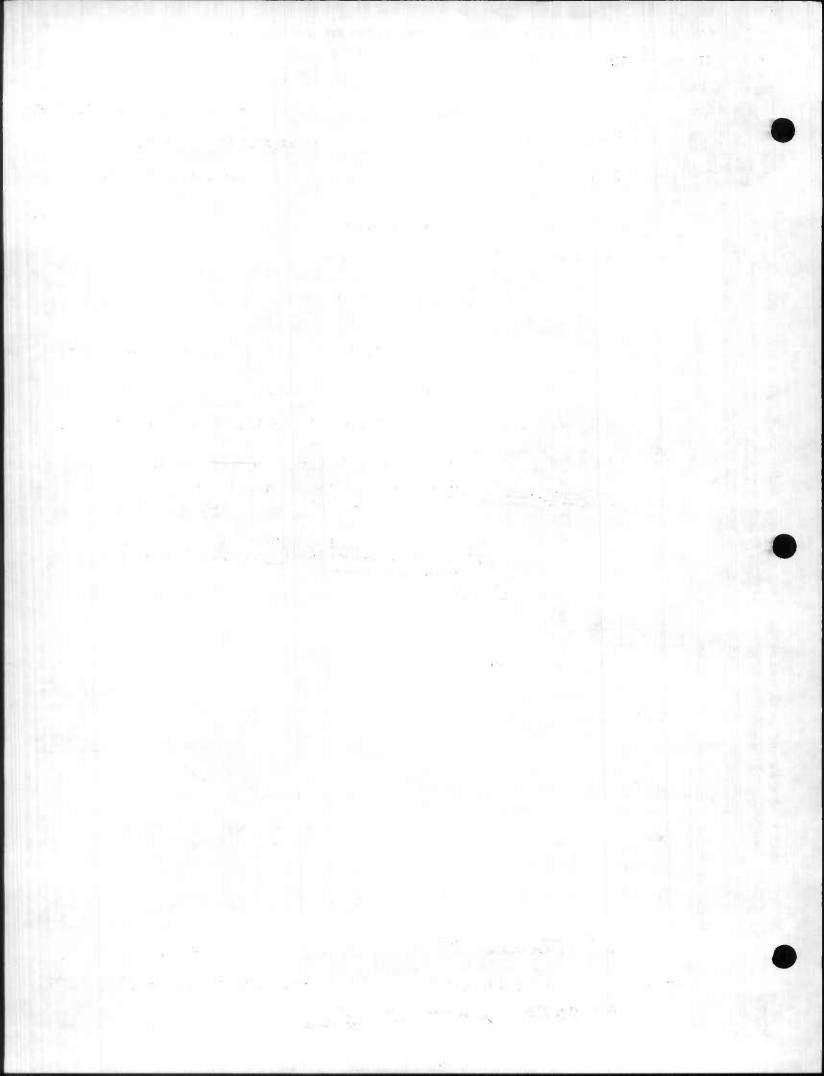
				Cei	tificate d	of Death	7		Reg. No.		
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fler death v	722 Crabb Avenue		edant Evar in U,S.	13.1		20850	rigin? (Sr	pecify Vas or N	Unite		ates
urs after	1 Navar Marriad 2 Married 3 Widowed 4 Divorced	Armed Fo	rcas? 2⊠No √a		Was Decedent f Yes, specify (1 ☐ Yes 2 ☑			Rican, atc.)	Bla Specif	ck, White	
ed within 72 ho ygiene. Ar than "natura nt, the Medeal	15. Decedant's (Specify only highast	Education grade complated)	1	6a. Deced	dant's Usual Oc kind of work do DO NOT use re	cupation ne during mo	st of worl	king	16b. Kind of B	usinass/I	ndustry
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filed within Hygiene. other than ent, the Men.	17. Fathar's Neme (First, Middla, La	ist)			Joan Mi		nar's Nam	ne (First, Middle	e, Meidan Sumar		:5
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2 should and Men and Men and Men and Men To To	19a. fnformant's Nama/Ralationship	(Type, Print)		19b. Mailir	ng Address (Str	eat and Numi	ber or Ru	ral Routa Numi	ber, City or Town	, Stata, Z	ip Coda)
Health a Health a Health a Sther tra	Betty Marie Asbu	ry/Daugh					lockv	ille, N	Maryland		
	20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Spe		Stata cem	atary, crar	sition (Nama o netory or other Memori	placa Marc		1999	20c. Location		
permit. Page Department of Important: If any Injury or once.	21. Signatura of Funaral Sarvica Li	censaa	M0019	8 Ř	Name and Action 100 West 1	Pumple Mont	hrey gomen	Funera ry Aven	1 Home/F ue 50-2805	Rockv	ille, Inc
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Examiner	disease or condition resulting in death)	a	umonia								1 month
ie in the second			Dua to (or a	s a consac	quance of):						
ficate be executed ficate be executed to the physician and is the burial-transit edical Examiner	Sequantially list conditions, if any, leeding to immediata cause. Entar Underlying Causa (Disaasa or Injury	b	Dua to (or as	s a consec	juanca of):					1	
Z enti	resulting in death) Lest	d	Dua to (or as	s a conseq	uance of):						
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aw requir	Congestive He	art Fail	ure					24a. Wa	s an autopsy formed?		Were autopsy finding available prior to completion of cause of daeth?
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sicien: The sector, page to Be Co	25. Was case referred to madical axaminar?	11					ca of Dea	th (Chack only	ona)		
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Lal or All is after all Directed in by	4 Homicida determin	ad 286. Place	of Injury - At home ng, atc. (Specify)	a, tarm, str	aat, factory, off	ica			own, Stata)	per or H	ural Routa Number,
To the Hospital or Attending I within 24 hours after death of the Funeral Director: After completely filled in by the funeral Medical Certification.		aminer: On tha be	best of my knowle asis of axamination nar statad.								
To the comp	29b. Signatura and titla of cartifiar	0.1	0.75	_	29c. Lic	ansa number			29d. Date sign	ed (Monti	h, Day, Year)
10	Honen	delen	200	M		D382	62		March 1	1, 19	99
	30. Nama and address of person when Anurita Mendhira					lip Dr	ive,	Olney,	Marylar	nd 20	832
State Registrar	31. Data filad (Month, Day, Year) MAR 0 2 1	32. F	gistrar's Signatur	g.	Spar	KN					



99-1183-011

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Medica		Robert		How	ard				MARCH	1, 19	99	1:03P.M.
kamine		4a Facility Name (If not institution, gi		r)					ocation of Death	4c. County	of Death	
		3412 HOUSTON BRA		Age /le ure	last birthday)	If Undar 1 Y	FEDEI		BURG 8. Dete of Birt		LINE	
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ם	-	10a. State 10b. County		10c. City	y, Town or Lo	ocation					1	Od. Inside City Lim
Examiner must be notified at	io	Maryland Caroli	ne		Federa	lsburg						1 ☐ Yes 2,50
20 M	Director	10e. Street and Number				10f. Zip Co	de			10g. Citizen of V	Vhat Cou	ntry?
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Control	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1 X Yes 2	5?	S. 13. V	If Yes, specify (or Hispanic Or Cuban, Maxica	in, Puerto	ecify Yas or No Rican, etc.)	Blac	k, White,	
Evalua	2	3 ☐ Widowed 4 🎖 Divorced	If Yes, Give Year or Dates		1970	1□Yes 2🕱				Specify	Blac	
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traumatic		19a. Informant's Name/Relationship	(Type, Print)						al Route Numbe	er, City or Town,		
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r other		20a. Method of Disposition 1 X Burlal 2 ☐ Cremetion 3 ☐	Removel from Stat		lace of Dispo ametery, cren	sition (Neme of metary or other	f plece)		Deta 3/9/99	20c. Location -	City or To	own, Stete
any injury or other to once.		4 □ Donetion 5 □ Other (Speci	fy)		. Vete	rans Ce	emetery		/8/99	Beulah,	Mary	land
		21. Signature of Funeral Service Lice	nsee			2. Neme end A			eral H	OMA		
e a					P	.O.Box	1687.	East	on Mary	land 216	501	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death est 3 Am 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1999 MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Corner of Wright & Reliance Roads Federal sburg Caroline If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **½**M 2□ F 85 217-36-0440 01/24/14 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Caroline Federal sburg 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21632 6845 Reliance United States Road 11. Marital Status 12. Was Decedent Ever in U,S. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, atc. Armed Forces Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grain & Poultry Farmer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fannie Tull Hastings William T. Hastings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6852 Reliance Rd., Federalsburg, MD 21632 Kim Wright/Granddaughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hill Crest Cemetery 3/5/99 Federalsburg, MD 22. Name end Address of Facility 21. Signeture of Funeral Service Licansee Framptom-Hawkins-Eskow Funeral Home, whal kow PO Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tnterval Between Onset and Death tmmediate Cause (Finel disease or condition resulting in death) CHRONIC Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes en autopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause

The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the aid be detached for been certificate has spital or Attanding Physician: Theoris after death.

neral Director: After this certificate y filled in by the funeral director, pa To the Hospital of within 24 hours at To the Funeral D completely filled

Physician

/Medical

Examiner

Director

Funeral

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id other than "natural", or itama 23a or 28a-f ahow avent, the Medical Expansion must be notified at

I Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If flem 27 is merked other than any injury or other traumetic avent, Its 90028.

Physician /Medical

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland-21248-50020 GS

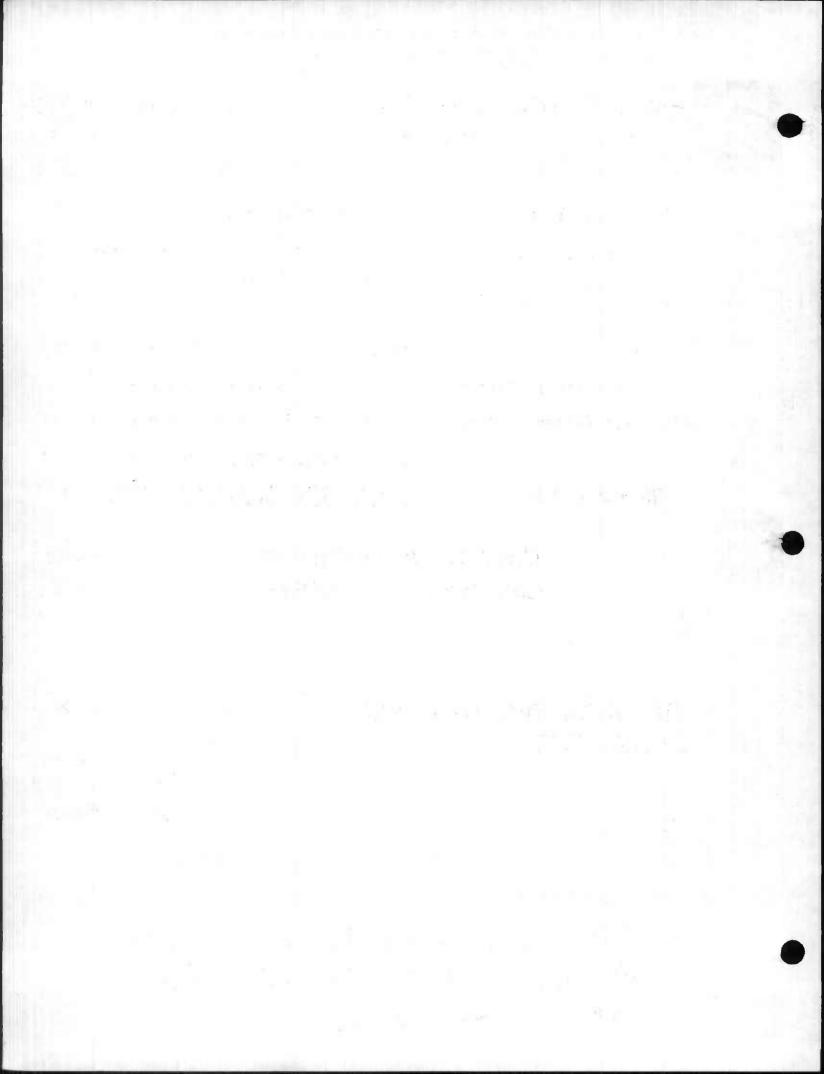
PIABE	1E	5			24a. Wes en autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of deeth?
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25. Was case referred to me examiner?	-				eath (Check only one)	
Yes 2□ No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ (OOA Other: 4 Nursing	Home 5 ☐ Residence 6 XOt	her (Specify) FIELD
27. Manner of Death 1 Naturel 5 P 2 Accident	ending vestigation		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how Injury occu	
	ould not be etermined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
29a. Certifier 1 Cer	tifying Phy dical Exam	ysician: To the best of my know etner: On the basis of examina and menner stated.	owledge, death occurre ation and/or investigation	d et the time, date and plecon, in my opinion, deeth occ	ce, and due to the cause(s) and mourred at the time, date and place	nanner as stated. , and due to the cause(s)
29b. Signature and little of d	rtifier		44 - 2	9c-l Icense number	29d thate sign	ed (Month Day Year)

On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. one) 29b. Sign 29d. Pate signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,





State of Maryland / Department of Health and Mental Hygiene 99 001.75

								Ce	rtificate (of L	Death		Reg. No.	J 34	10
				1. Decedent's Nam	ne (First, Middle,	Last)						2. Dete of D	eeth		3. Time of Death
		Physic		1	RETHIE		MAE	1	HARVEY	•		Month Feb.	Dey 23	Year	1, 15
	Y	/Medi		4e. Fecility Neme (-	TATE A 19 T		b. City, Town, or L			y of Deeth	1 Am
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	1			5. Sociel Security N				L° . last birthday	If Under 1 Y	oor	If Under 24 Hrs.	Air		larfo	
		Funeral				.Sex 1 □ M 2 👿 F		s. last birthday, Yrs.		eys	Hours Min.	8. Dete of Bi	ey Year	9. Birth	piece (Stete or Foreign
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		pu *		Usuel Residence of 10e. Stete	10b. County		10c C	ity, Town or L	ncation						10d. Inside City Limits
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		N 0 0	S S	Md.		rford					rest H:	<u> </u>			1 Yes 2 No
		\$ P	Director	10e. Street end Nu	mber				10f. Zip Co	de			10g. Citizen of	Whet Cour	ntry?
		death with the Meryland	<u>a</u>	251	3 Sandy	Hook	Road				21050		U.	S.A.	
		de de	Funeral	11. Marital Status		12. Wes Dec	edent Ever in	U,S. 13.	Was Decedent	of Hi	ispenic Origin? (Sp n, Mexicen, Puerto	ecify Yes or N	o- 14. Ra	ce - Americ	can Indien,
	0	effe of the		1 Never Marr	ried 2 Merried		2 No		1 ☐ Yes 217		Specify:	, , , , , , , , , , , , , , , , , , , ,			etc.
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	21215-0020	72 hg	Completed	/6	15. Decedent's			16a. Dece	dent's Usuel O	ccupe	etion fu <i>ring</i> most of work ')		16b. Kind of E	Business/In	dustry
	2	in a	를	Elementery/Seco	cify only highest onders (0-12)		1-4or 5+)	life.	DO NOT use re	etired))	any			
	21	d wil	00	5	, (,	-	_		Hous	ew	rife		H	lome	
	P	othy oth	Be	17. Fether's Name	(First, Middle, La	st)					18. Mother's Nam	e (First, Middle	, Meiden Sume	me)	
	<u>a</u>	lenta Ked ice	ToB	.To	ohn		B	onham			Je	tti		S	Shoupe
	2	shot mar	-	19a. informant's N		(Type, Print)			ng Address (St	reet e	and Number or Rui		per. City or Town		
	Ž	the street		Shelby	Slack	/Daugh	ter		e as #						,
	0	ges 1 end 2 should be filed within 72 hours efter death with the Merylar to f Health end Mental Hygiene. It for Health end Mental Hygiene. If item 27 is marked other than "neturel", or items 23a or 28ef show or other treumatic event, the Medical Examiner must be notified at		20e. Method of Dis		/ 1000 811	4.7	Piace of Disp	osition (Neme o	of		-Date -	20c. Location	- City or To	own State
	0	ages of of			☐ Cremetion 3		State	cemetery, cre	metory or other	plec		2726			
	Baltimore, Maryland	permit. Peges 1 and 2 should be filed within 72 hours efter death will Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or itema 23a lamp lajury or other treumetic event, the Medical Examiner mant pance.			5 ☐ Other (Spe		H1					T999	Fallst	on,	Maryland
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O.	-	00 = 60		P3/1/.	Dlack	den T	turk:	111			sville			Home	, 4 may .
^				23a. Pert1. Enter t	the diseese, or co	mplications that	ceused the dec	th. Do not en	ter the mode of	dyln	g, such es cardiac	or respiratory	errest,		Approximete intervel Between
	1	Physician		SHOCK, OF FIEE	at leilule. List on	ly one ceuse on e	eci ine u								Onset end Deeth
	F	/Medicai		immediete Ceuse	(Finai	Ca	-a bini	100	Jan 1	L -	cident	L			with .
		Examiner		diseese or condition resulting in death)	on	a. 🗡				TC	ciclen				ter hour
			ē				Due to	or es a conse	quence of):						_ 1
		nsit	듵			b								- 12	ter hour
	*	eath certificate be executed attending physician and for use as the buriel-trensit	Examiner	Sequentielly list co if eny, leading to in ceuse. Enter Under	nditions, nmediate		Due to (or es e conse	quence of):					i	
	68760,	be e iclar buri	<u>e</u>	Ceuse (Diseese or	Injury	C								i	
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	×	Jing Jing Se es	M		- (d								i	
_	Bo	ath o	lan												
3		The law requires that the death site hes been signed by the atter page 2 should be deteched for a	Physician	Part ii. Other signif	ficant conditions	contributing to d	eath but not re	sulting in the u	nderlying ceus	e give	en in Pert i.	23b. Did	tobecco uee co	ontribute to	o the cause of death?
1	P.0	that the	F.	xſ.	- 60.	266	0.		too			1 🗆	Yes 2 -No	3 □ Pro	bably 4 Unknown
16	Ś	es tha igned be de	by		SUFIN	ners	De	mer	1112						
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+	8	w requ	Set									pen	ormed?	co	empletion of ceuse deeth?
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	<u>a</u>	w -										1 🗆	Yes 2☐No	1[Yes 2 No
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ARVEY			on:	27. Menner of Deet Naturei	th 5 ☐ Pending	28a. Dete (Mon	of injury th, Dey Year)	28b. Time of injury		Injury Work	et c?	28d. Describe	how injury occu	rred	
7	Division	leath.	Cat	2 Accident	investigat				М	101	Yes 2 □ No				
4	Ξ	or Attendent efter deat Director:	=	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 28e. Piace	of Injury - At I	nome, farm, st	reet, factory, off	lice		28f. Location ((Street end Num wn, Stete)	ber or Rure	el Route Number,
		s effe	Certification:				3, (,,							
		To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune		29a. Certifier (Check only	1☐ Certifying F	hysician: To the	best of my kn	owiedge, deat	h occurred at th	e tim	e, dete end plece,	and due to the	ceuse(s) end m	anner as s	tated.
		n 24 n 24 ne Fe	edical	one)	2 Medical Ex	end men	asis of examin ner stated.	ation and/or in	vestigetion, in r	ny op	oinion, death occur	red et the time,	date and place,	, and due to	the ceuse(s)
		To the To the Com	Σ	29b. Signature end	title of certifie				29c. Lic	ense	number		29d. Date signe	ed (Month,	Dey, Yeer)
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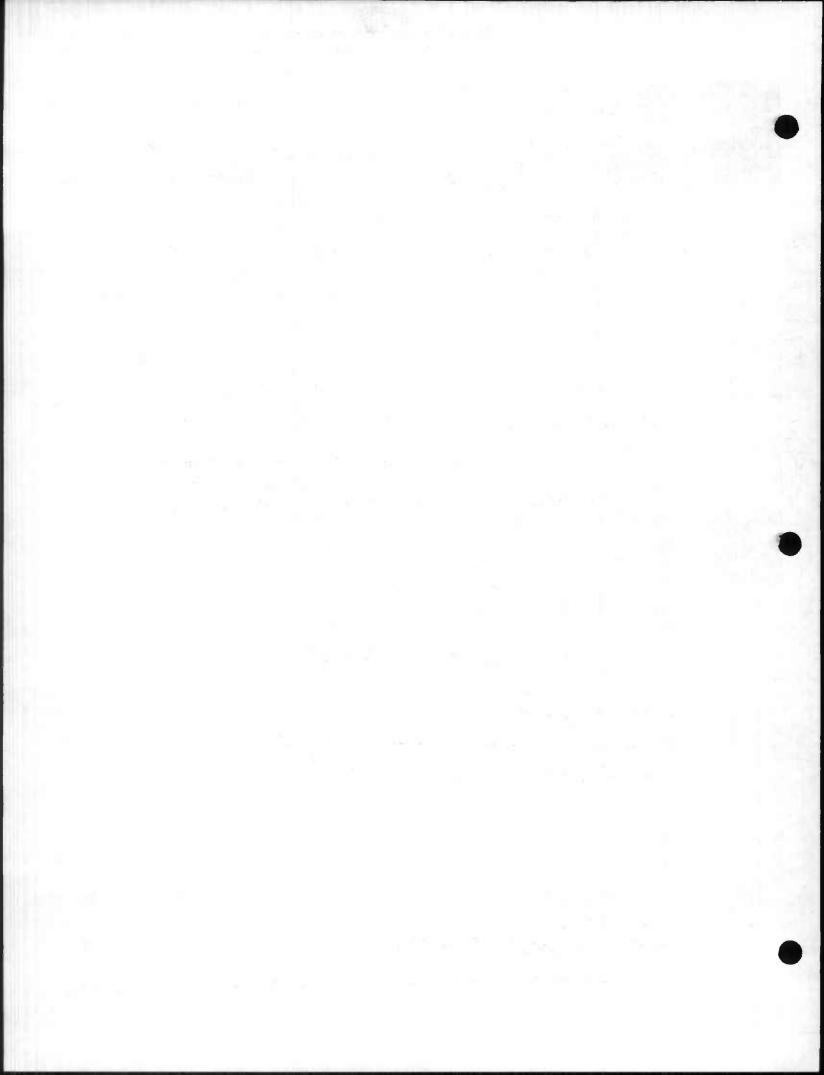
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				(Certificate	e of	Death		Reg.	No.	Ud	4/0	
		1. Decedent's Neme (First, Middle,	ast)					2. Date of	f Death			3. Time of Death	
	hysician	Lonnie Charle	Harris					Marc		999	Year	8:05 AM	
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4		VA MHCS FORT HO	WARD DIVISIO	N			Fort	Howard		Balt	imore	2	
Fui	nerai	5. Social Security Number 6		yrs. lest birth	Months	1 Year Days	If Under 2 Hours		Birth Day, Ye		9. Birthple	ace (State or Foreig	n
	ector	430-94-1867 Usual Residence of Decedent	№ 2 F 51	Y	rs.			Marc				nsas	
with the Maryland	i u	10a. Stete 10b. County	10	c. City, Town	or Location			44		4	10	d. fnside City Limits	
Ma A	to to	Maryland Cec	1 F	ort De	nosit							Yes 2□No	
6 8	be notified at Director	10e. Street and Number		010_00	10f. Zip	Code			10g.	Citizen of W	hat Count	ry?	
W 455	18	163 North Main	Street			2	21904		U	IS			
90 90	iber mat	11. Meritel Stetus	12. Was Decedent Eve Armed Forces?	r in U,S.	13. Was Deced	ent of H	lispanic Orig	in? (Specify Yes of Puerto Rican, etc.	r No-		- America		
Maryland 21215-0020 42 should be thed within 72 hours after this and Mental Hygiene. 7 he marked other than "natural" or the	by by	1 Never Married 2 Married 3 Widowed 4 Divorced			1□ Yes 2		Specify:			Specify:			
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willing	9 6	Elemantary/Secondary (0-12)	College (1-4or 5+)		lifa. DO NOT us	e retired	d)	or working					
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should and Men	10	Alton Harris						Verla S:	Lmpso	n			
Aar 2 sh and and		19e. Informent's Name/Relationship						r or Rural Route N					
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Pages 1	04 01	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		cemetery	Disposition (Nem, crematory or of	e of her plac	ce)	Dete	20c	. Location - (City or Tov	wn, Stete	
Pag Pag	6	4 Donetion 5 □Other (Spec		Garri	son Fore	est	No. 13	3/1/99	Ow	ings l	Mills	MD	
Baltimore, semit. Pages 1 at Department of Heat	F SI	21. Signeture of Funeral Service Lic	ensee		22. Name end	d Addra	ss of Fecility	Beard					
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T 5	2 8		d										
death cert	foru						10.0				Į		
O. the d	etached for usa	Part II. Other significant conditions	contributing to death but no	ot resulting in t	the underlying ca	use giv	en in Part f.	23b.				the cause of death	
P that		Cancer, Tons	il, Seizure	Disord	er.				₹ Yes	2□ No	3 Prob	ably 4 Unknow	/n
O = 0	d by							24a	Wes en ei	utonsv	24b. We	re eutopsy findings	
reque	should	A							performed		con	nilabla prior to	
Rec e lew	m P											leath?	
= F #	Com	``	·						1 🗆 Yes	2 JyNo	1	Yas 2 No	
of Vital Physician: The	director,	25. Wes case referred to medical examiner?	Hospitel: 35			Oth	or:	of Death (Check o					_
Phy of		1 Yes 2 No	15 Inpatient 28a. Deta of Injury	2 ER/Outp		^	4 LI NUI	rsing Home 5 28d Desc		6 ∐Othe)	
C 2 2	fune	1 Netural 5 □ Panding	(Month, Day Ye		ury M	Bc. Injur Wor	k? Yes 2□N			inguity coodiii.			
Division Tor Attending after death. Director: After	led in by the funer. Certification:	3 Suicide 6 Could not	be co. Di(1-1	At home fem			100 201		on (Street	t and Numbe	er or Rura	l Route Number,	
Oiv A parties	in b	4 ☐ Homicide datermine	building, etc. (S		ii, stiest, rectory,	Onice		City o	r Town, St	tete)	,, 0, ,,0,0,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division Nospital or Attendi		29e, Certifier 1 Certifying F	hyelcian: To the best of m	v knowladae	deeth occurred a	t the ti-	ma date and	I place, and due to	the cauc	B(s) and me	nner as et	ated	
Hoe 124 h	pletely fil	(Check only 2 Medical Exp	miner: On the basis of exa	minetion and/	or Investigation,	in my o	pinion, deet	h occurred et the t	ime, dete	end placa, a	nd due to	the ceuse(s)	
To the within 2	Me Me	29b. Signetare and title of certifier		2	29c.	Licens	e number		29d.	Date signed	(Month, L	Day, Year)	
F 3 F	0	D. 4.	o Tan (Ma D	T	1	101	50	21.	1/1999		P. S. T. T. S.	
	1 6	30. Name end address of person wh	completed cause of the	(ltem 22a) (7	una Print)	11	T1-	-0	1 3/:	1/1999			
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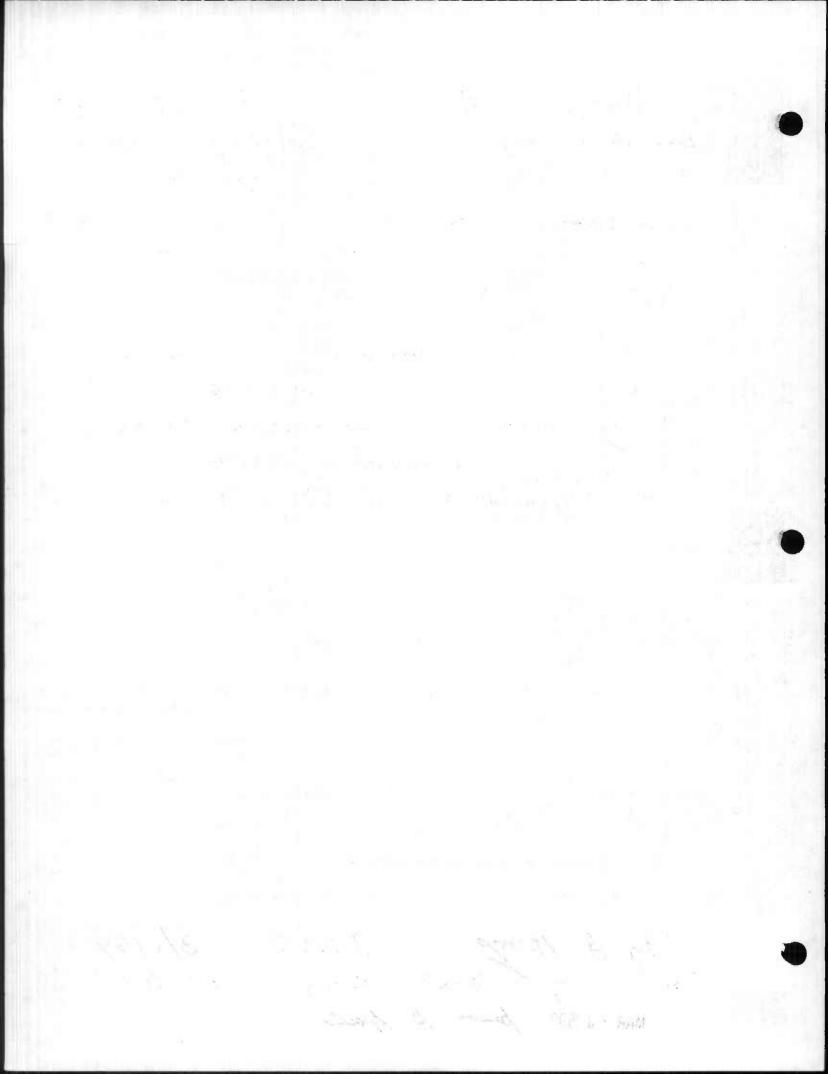
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			State of Maryland / Department of Health a Certificate of Death		giene	84.77
			1. Decedent's Neme (First, Middle, Last)	2. Dete of Dec	eth	3. Time of Death
//	ysicia Medic camin	al	SOPHIA DORSEY ANN HERBERT 4e. Fecility Neme (If not institution, give street and number) 4b. City, Tow	March (12:45PM
			Civista Medical Center La Pl	ata	Charles	
	neral ector		5. Social Security Number 6. Sex 1 M XF 7. Age (In yrs. lest birthday) Yrs. Months Deys Hours	Min. 8. Dete of Birt	h 9. Birtt V. Year) 9. Birtt Col	piece (State or Foreign intry) arvland
1 1	-	1	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Marylar of show	notified at	to	MD Charles Faulkner			1 ☐ Yes 21 No
7 with the 23 or 2	9	Funeral Director	109. Street and Number 1001. Zip Code 20632		10g. Citizen of Whet Co.	untry?
020 ours atter des	3	ρ	11. Merital Stetus 1 Never Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces: 13. Wes Decedent of Hispenic Original If Yes, specify Cuben, Mexican, In Yes, Sive Year or Dates:	n? (Specify Yes or No- Puerto Rican, etc.)		
*1215-0020 within 72 hours at ene.	.98	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+)	of working	16b. Kind of Business/l	ndustry
7 64 252	event, the M	S -	12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother	s Name (First, Middle,	Home	
Maryland Maryland vd 2 should be file lith and Mental H; 27 is marked oth	9 0	To Be		ie Higgs		
arylar should by	umat	-	19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number			(p Code) 20632
	er tra		Philip A. Herbert, Jr. / Son P.O. Box83 10020	Wrens Ne	st Rd.Fau	lkner,MD
TOPE TOPE	or ott		20e. Method of Disposition 1 Buniel 2 □ Cremetion 3 □ Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)	Date	20c. Location - City or T	own, Stete
Baltimore,	any injury	-	4 Donetion 5 Dother (Specify) United Methodist Cen	n.3/9/99	Dentsvill	e,MD
Ba Depa Impo	any is		21. Signature of Funeral Service Licensee AREHART-ECHOI P.O. BOX 567	LS FUNERA	L HOME P.	A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one ceuse on each line.	ardiac or respiretory er	rest,	Approximete Intervel Between
Physic /Med Exami	icai iner		Immediate Ceuse (Finel disease or condition resulting in deeth)			Onset end Death
IS, P.O. Box 68760, es thet the death certificate be executed igned by the ettending physician end	the bu	Physician/Medical Examiner	Sequentially list conditions, it eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Lest	-		
e dear	of ber	sici	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Dld 1	obecco use contribute	to the cause of death?
P.O. the the de by the	detec	Ph	Coronary artery deserve,	10	res 2 No 3□Pr	obably 4 ☐ Unknown
ecord aw requir	2 should	Completed by	Chronic obstruction pulmonary de		med?	Vere eutopsy findings veileble prior to ompletion of cause f deeth?
The off	page.		Recent preumonea, allogher gish	tes 101	es 25No 1	☐ Yes 2☐ No
of Vital F Physician: The	rector		examiner?	of Deeth (Check only o		
Of Phys	D B	2	1 Eunpatient 2 Envoutpatient 3 DOA 4 Nurs		lence 6 Other (Spec	ify)
ion ath.	e fune	ation	27. Menner of Deeth 1		,,	
Division To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: After	completely filled in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Ru n, State)	ral Route Number,
he Hospit in 24 hour he Funera	pletely fille	edicai	29a. Certifier (Check only one) 12 Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth and manner stated.	piece, end due to the occurred et the time,	ceuse(s) end menner es date end ptece, end due	steted. to the ceuse(s)
To the	E 00	Σ	29b. Signature end title of certifie 29c. License number		29d. Dete signed (Month	, Dey, Year)
			D-08370		3/5/9	9
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul E. Pritchett, MD 118 LaGrange Avenue P.O. Box 1	217 1 - 11	. 14 -	
Re	Stat	е	31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture	JI/ La Fla	ta,Maryland	20646



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Commonwealth Comm					State of Mary		ertificate of			eg. No.	9 48478
Prince P				William	Hall				March	Dey /	3. Time of Death 1999 4:050.m
Use State of Detailed Use Us		Funeral	ner	Deer'S Head (5. Se 5. Sociel Security Number 6. Se	enter 7. Age (In			r If Undar 24 Hr	Soury s. 8. Date of Birth (Month, Day)	W Year)	9. Birthpieca (State or Foreign Country)
Marykand Somerset Princess Anne 100 Citizen of White County? 100 Citizen of White Coun	-	p .		Usuel Rasidenca of Decadent					July 30	, 1911	
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DIXLE (**IUEPIN**), Executress	ylaı	Menta Menta arkad artic e						Zoe H.	Boswell		
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Physician Modern Process And Address And Process And Process And Process And Address And A	more,	Pages 1 and and of Health: If Norm 2 y or other		20e. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ F	lemovel from State	cemetery, cre	emetory or other pl	eca)	Dete	20c. Location -	City or Town, Stata
Physician Modern Process And Address And Process And Process And Process And Address And A	altir	parimit. P parimit portan y Injur Sa.				2	2. Name end Addi	ess of Fecility		Salish	ury, Md.
Physician (Modical Examiner) Part Modified Part Part Modified Part Part Part Modified Part Part Part Modified Part	8	SSESS		Inness L. Xle	KMWW002	95	Hinman Fo	Jneral Ho	ome, P.A.	es Anne	e Md 21853
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The contribute of the cause of death? Contribute Con	68760,	icate be ax physician s tha buria		that initieted events	theum	onia					1 month
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24e. Wes an eutopsy performed? 24e. Wes an eutopsy performed? 25. Wes case referred to medical axeminer? 1 Yes 2 No 25. Wes case referred to medical axeminer? 1 Yes 2 No 26. Place of Death (Check only one) 27. Menner of Death 1 No price 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 1 No price 1 1 Inpatient 2 ER/Outpatient 3 DOA 28. Deat of Injury M 1 Yes 2 No 29. Lication (Street and Number or Rural Route Number, City of Town, State) 29. Signeture and address of person who completed cases of deeth (Item 23e) (Type, Print) 29. State 24e. Wes an eutopsy performed? 24b. Were autopsy indings evelible period to completed of cause of deeth 1 Yes 2 No 26. Place of Death (Check only one) 27. Menner of Death 1 Neuron 5 Pending 1 Yes 2 No 28. Deat of Injury 28c. Injury of 1 Yes 2 No 28c. Injury of 1 Yes 2 No 28c. Certifier 2	B	e deat the att	sicia	Pert II. Other significant conditions con	tributing to death but not	resulting in the	underlying cause g	iven In Pert I.	23b. Did to	bacco use cor	ntribute to the cause of death?
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27. Menner of Deeth 1 Menture in Signature i	5	ralclar s cartif directo	o Be	axeminer?	lospitel:	2 ☐ ER/Outpatie	nt 3 DOA	ther			or (Spacify)
30. Neme and address of person who completed case of deeth (Item 23e) (Type, Print) Inja J. Hwang, M.D., P.O. Box 2018, Salisbury, M.D. 21802-2018 State 31. Date filed (Month, Day, Year) 32. Registrer's Signeture	ion oi	or Attending Physical Correctors After this Sirectors After this In by the funeral d		27. Menner of Deeth 1 Neturei 5 Pending			of 28c. Inju	ork?	_		
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State 31. Date filed (Month, Day, Year) 32. Régistrer's Signeture				30. Neme and address of person who co	mpleted case of deeth (Item 23e) (Type,	Print) Salic	him M	7 2181	2-21	318
				31. Date filed (Month, Day, Year)	32. Registrer's Si	gneture) 041151	ury, in	0 0100	X-XL	10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth March 6, Dey 1999 Yee **Physician** Roberta Virginia HARRIS 0600 /Medical 4a. Feclity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Algust 9, 1900 Birthplece (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours Months 1 ☐ M 2 🗓 F 98 214-11-3024 Yrs **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Director Maryland Frederick Frederick 10q. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 200 East 16th Street 21701 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be Charles Staley Fdith Smith 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Jamie Irving Harris/Grandson 7818-A Edgewood Church Rd., Frederick, MD 21702 20b. Plece of Disposition (Name of cemetery, cremetery or other plece)
Mt. Olivet Cemetery 20e. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removal from State March 9, 1999 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Service Licensee 22. Name and Address of Fecility Keeney & Basford Funeral Home 23a. Pert1. Enter the disease, or complications that cau gd the death. Do not enter the mode of dying, such as cerdiec or respirefory errest,

Approximate shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Cardiovasculas dream /Medical Immediate Ceuse (Final diseese or condition rasulting in death) **Examiner** Due to (or es e consaguence ot) Examiner Sequentielly list conditions, if eny, leeding to immadiate ceuse. Enter Undarlying Ceusa (Disaasa or injury Due to (or es e consequence ot) Physician/Medical thet initieted evants resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara eutopsy tindings eveileble prior to completion of cause of daeth? 24a. Wes en eutopsy Completed 1 ☐ Yes 2 ☐ No 25. Was cesa ratarred to medicel exeminer? Be 26. Placa of Death (Check only ona) Hospitel: 1 ☐ Yes 2 No Other: 2 1 Inpatient Will Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpetient 3 DOA 27. Mapner of Deeth 28a. Date of injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, tectory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowladga, daath occurred et the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end titie of certifier D16675

Wayne Allgaier, M.D., 401 Mountville Road, Jefferson, Maryland 21755

State Registrar

30. Name end eddress of person who competed cause of death (Item 23a) (Type, Print)

8 1999

32. Registrar's Signature

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Item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Moustal Examiner must be notified at

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After this funeral

ne Hospital or Attending Pl n 24 hours efter death. ne Funeral Director: After th

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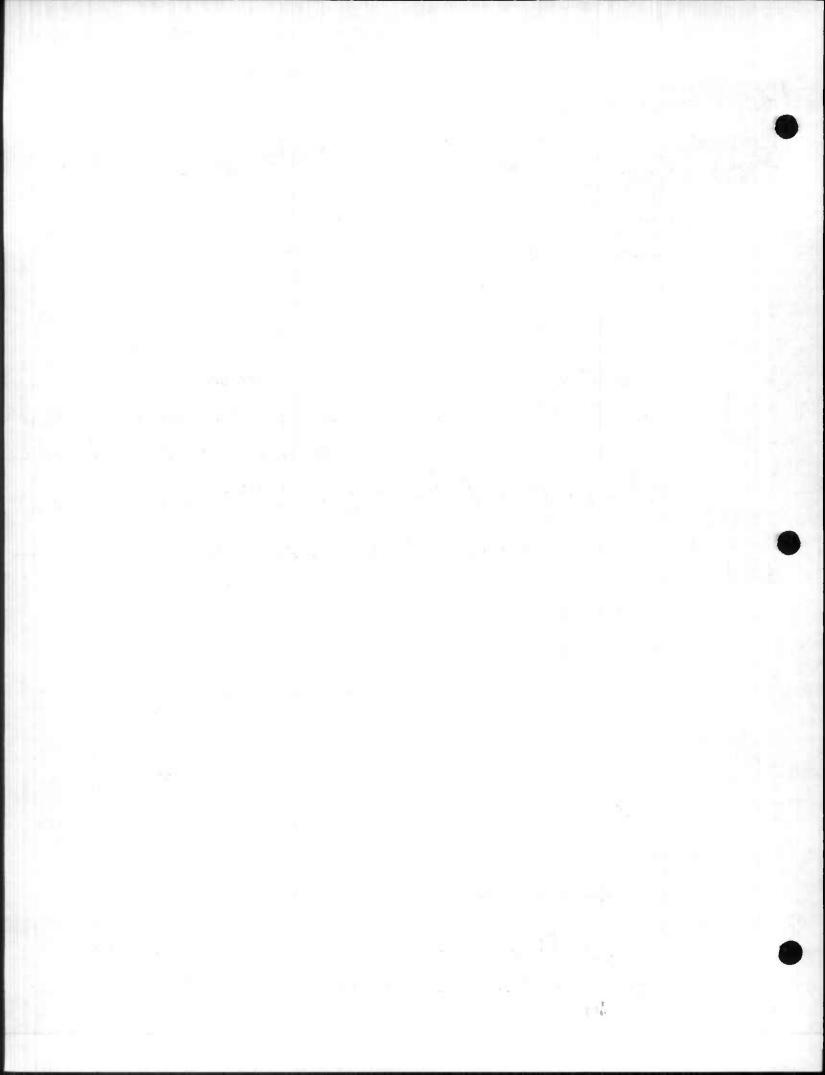
Box 68760.

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Division of Vital Records,

permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other treumstic event

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Carolyn Lucille Hackler March 6, 1999 5:20 A.M. 4e Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Frederick Memorial Hospital Frederick Frederick Hours Min. 8. Deta of Birth (Month Day, 1941) 5. Sociel Security Number If Under 1 Yaar Birthpleca (Stete or Foreign Country) Vennont. 7. Aga (In yrs. last birthdey) 1□ M 2□ F 54 226-58-5068 Yrs. Usuel Residence of Decedent 10a Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits M. Frederick Middletown 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8600A Myersville Rd. 21769 U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - Amaricen Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yaer or Detes: 1 Navar Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) legal secretary law firm 18. Mother's Neme (First, Middle, Maiden Surnema) 17. Fether's Neme (First, Middle, Last) Richard L. Collins Joyce Camo 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 8600A Myersville Rd., Middletown, Md. 21769 John S. Hackler (Husband) 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20c. Location - City or Town, Steta 20e. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete 3/9 Smithsburg, Mi. 4 Donetich 5 Other (Specify) Smithsburg Crematory 22. Name and Address of Facility Donald B. Thompson Funeral Home 21. Signatura of Funaral Service Licenses 31 E. Main St., Middletown, Md. 23a. Part T. Enter the disease, or complicate multhat caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one course on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) x6 en sice Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) En 56 23b. Did tobacco use contribute to the cause of death? Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy 2 No 1 Yes 2 No 25. Wes cese referred to medical examiner? 1 Yes 2 No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 SInpatient 2 ER/Outpetient 3 DOA

Physician /Medical Examiner

tha death certificeta be executed

Division of Vital Records, P.O. Box 68760

or Attending

Hospital c 24 hours el Funeral D

within 2

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Malical Examiner main be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter deeth v
Department of Health end Mental Hygiane, rish procramt: If fram 27 is marked other than "natural", or ferre 29a any injury or other traumatic event, tra

Baltimore, Maryland 21215-0020

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Examiner Physician/Medical

the ettending physician end hed for use as the buriel-transit signed by t has After this uneral eftar death. in by

þ Completed Be 10

Certification: Medical

(Check only one)

29b. Signatura and titla of cartifiar

27. Menner of Deeth

2 Accident

4 Homicide

3 ☐ Sulcide

5 Pending invastigation 6 Could not be determined

28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

28c. injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

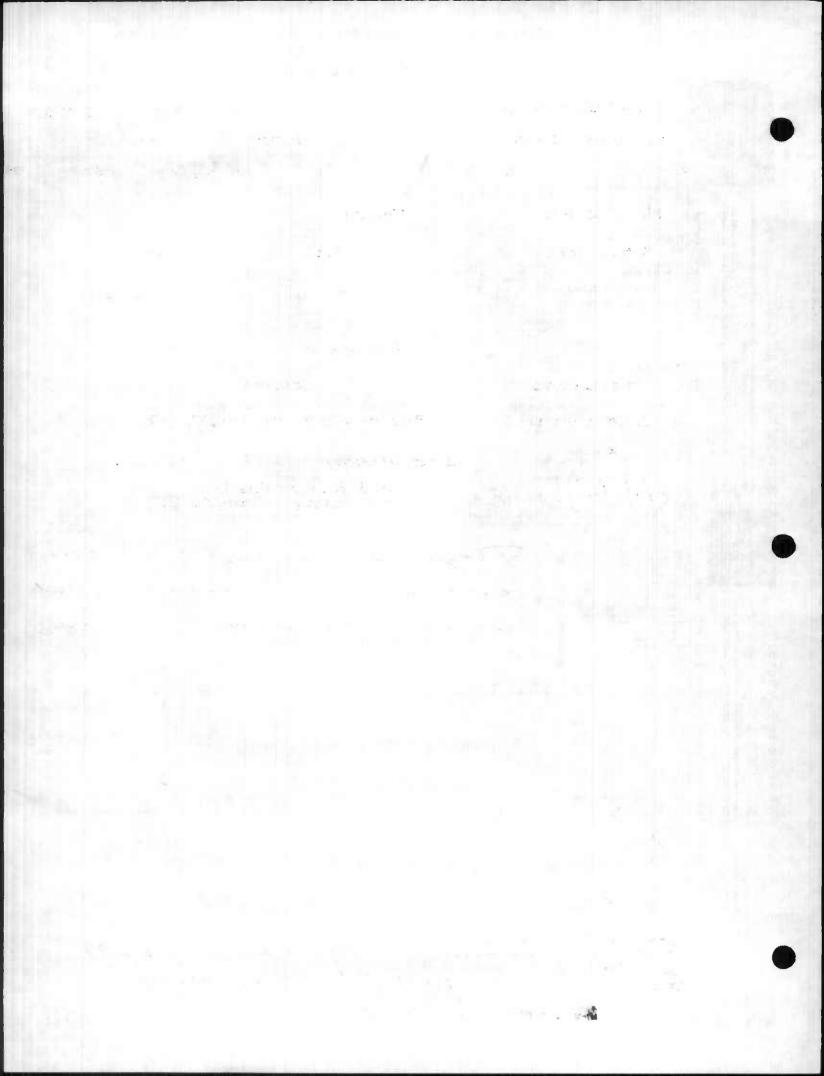
2 Medical Examinar: On the basis of axeminetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end menner stated. 29c. Licansa number 29d. Date signed (Month. Dev. Year)

30. Name and add f person who completed cause of deeth (Item 23a) (Type, Print) 712 Street Sal

32. Registrar' Signeture 1999 **•**

State Registrar

completaly



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middla, Last) Dey Month Yeer **Physician** Cecil Newberry HUGHES February 20,1999 6:53am /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, giva street and number) Examiner William Hill Manor Talbot Easton If Under 1 Year If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In vrs. last birthdev) Birthplece (State or Foreign Country) **Funeral** Days Months 1♥M 2□F Hours 96 Oct. 23, 1902 Director 578-05-6177 Texas Usuet Residence of Decedent the Marylend 10c. City, Town or Location 10e. Stete 10d. Inside City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Talbot Easton 10e Street and Number 10f Zip Code 10g. Citizen of What Country? with 501 Dutchman's Lane 21601 U.S.A. Funeral death 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amaricen Indien, 12. Wes Decedent Evar in U,S. Armed Forcas? 11. Marital Status Black White etc. filed within 72 hours eftar | X Yas 2 □ No 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 □ Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) Unknown Salesman Paper marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Heelth and Mental Hyant: If Item 27 Is marked oth lury or other traumatic even Be Joseph Newberry Hughes Josie Aldora Phelps 19b. Melting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 21658 Annie Mary Webb/Daughter 110 Nash Drive, Queenstown, MD 20b. Plece of Disposition (Neme of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete cametery, cremetory or other pleca) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Feb. 23, Lincoln Cemetery Brentwood, MD 21. Signature of Funeral Sarvice Licensee 22. Nama and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home P.A. 106 Shamrock Road, Chester, MD 23a. Part1. Enter the disease, or complications that caused his death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting In death) /Medical 5 d Examiner Examiner the death certificeta be axacuted physician end s tha buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): ettending pl signed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy Completed completion of cause of death? cartificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifict staly filled in by the funaral director, I 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes / 2 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Invastigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours aft To the Funerel Di completaly filled in 29a. Certifier 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

State Registrar

31. Dete filed (Month, Dey, Year) **FEB 2 5 1999**

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

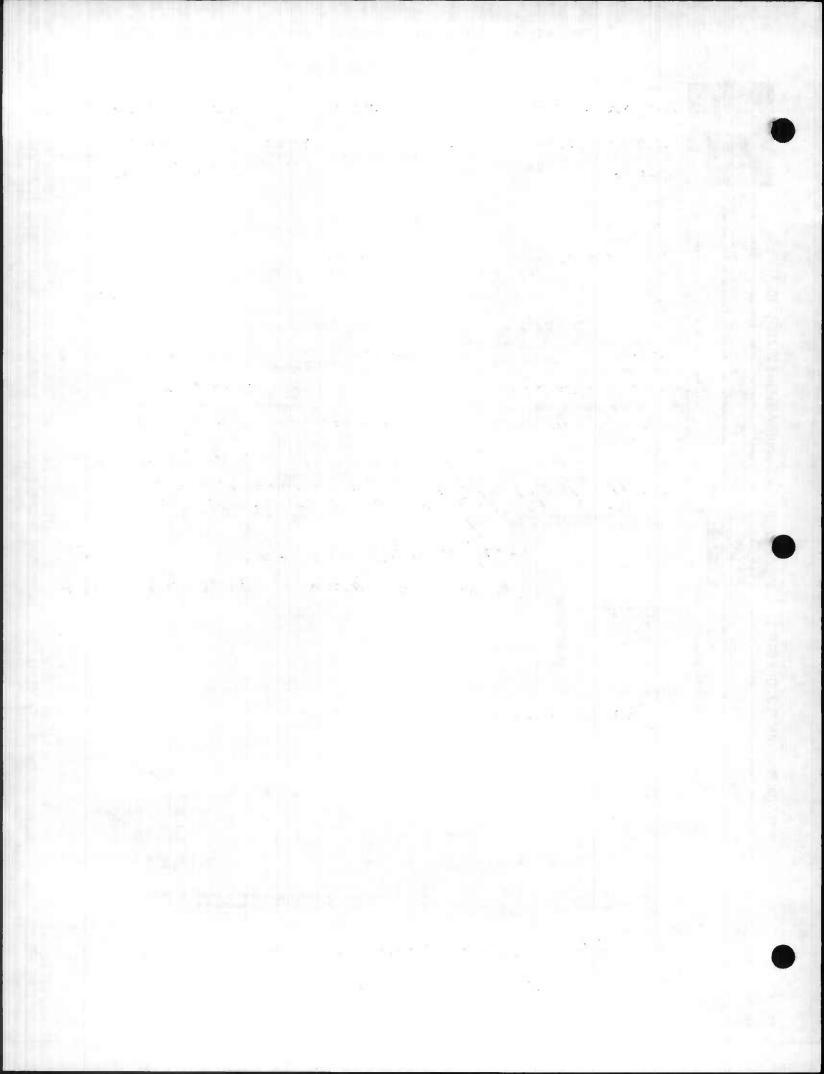
29b. Signature and titla of certifies

William H. Wood, MD,

506 Idlewild Avenue, Easton, MD 32. Registrar's Signature

29c. Licensa number

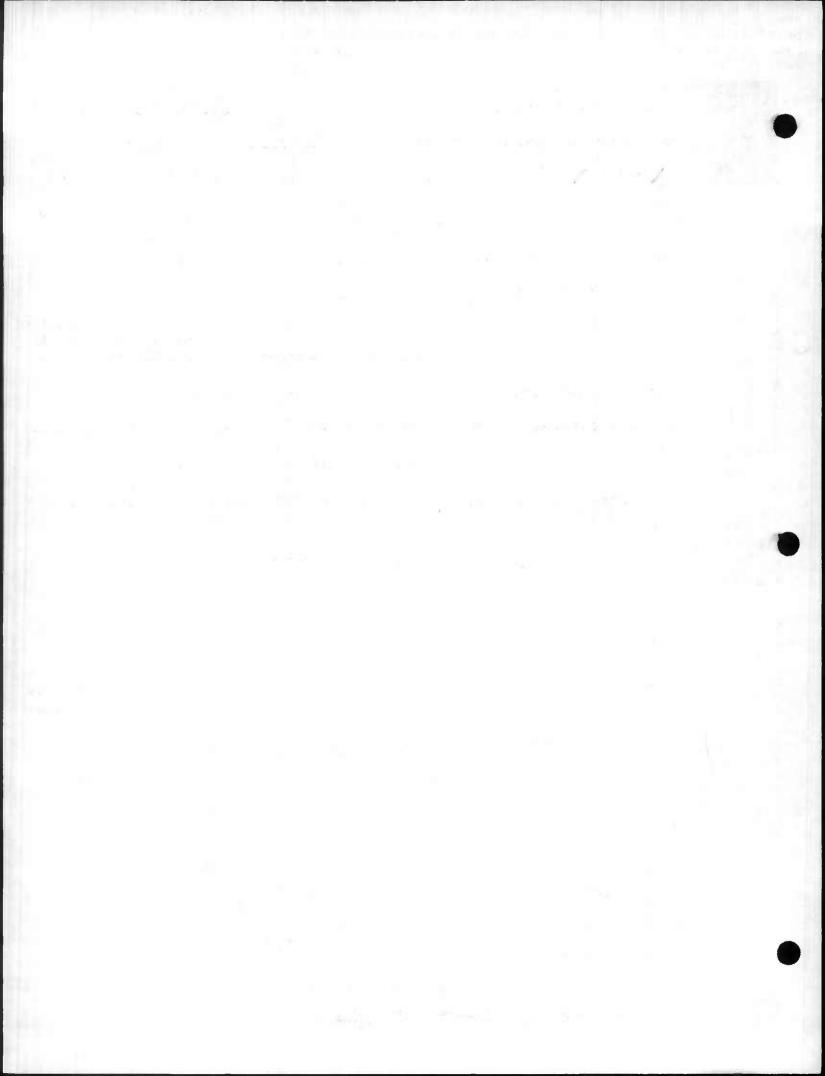
29d. Date signed (Month, Dey, Year)



Amended #4,03/08/99, T.M. Kent Co Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month James Edward Hynson 2/:22 Feb. 23, 1999 /Medical 4e. Facility Name (If not institution, give street end numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent & Queen Anne's Hospital Chestertown | CDESCEL COWE.
| If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Jan . 15, 1924 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplace (Stata or Foraign Country) **Funeral** 13 M 2□ F Yrs. Director 218-16-5274 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limits notified 1 Yas 2N No Director Md. Kent Chestertown 10e. Street and Number 10g. Citizan of What Country? iner mant be n filed within 72 hours after death with 23164 Baywood Ct.Apt.13-D 21620 12. Was Decedant Evar in U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. r than "ristural", or iten the Medical Examiner 1 X Yes 2 No if Yas, Give Year or Datas: WW2 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 M No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Kent Hygiene. Co.Commissioners Elementary/Secondary (0-12) Collega (1-4or 5+) Sanitation Dept. 9th Sanitation Worker 7 is marked other traumatic event, to permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: It Nem 27 is marked oths any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surnama) 86 Gilbert Hynson Sr. Helen Butler 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rural Routa Number, City or Town, Stata, Zip Code) 23164 Baywood Ct.Apt.13-D Chestertown, Md. Mrs.Mary E.Hynson(Wife) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 2/27/99 1 █ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) St.George U.M.Cem. Worton 21. Signature of Funeral Sarvice Licensee 22. Nama and Address of Fecility les WALLEY FUNERAL HOME Chestertown, Md. Inter the disaasa, or complications that caused the dea(f). Do not enter the mode of dying, such as cardiac or respiretory arrast, or haar failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed physician and the buriel-transit Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated avants rasulting In daath) Last Dua to (or as a consequence of): Box 68760, Due to (or as a consequance of): P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records. þ 24b. Wara eutopsy findings available prior to Completed 24a. Was en autopsy complation of causa 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No of Vital or Attanding Physician: Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only gna) Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 Yas 2000 Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral i 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred Division 1 Natural 5 Panding invastigation 2 Accidant 6 Could not be datarminad 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Data signad (Month, Day, Year) 19 allen no. 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Kin Kue Wun M.D.223 High St. Chestertown, Maryland 21620 31. Deta filad (Month, Day, Yaar) 32. Registrar's Signatura Registrar FEB 2 6 1999



State of Maryland / Department of Health and Mental Hygienen

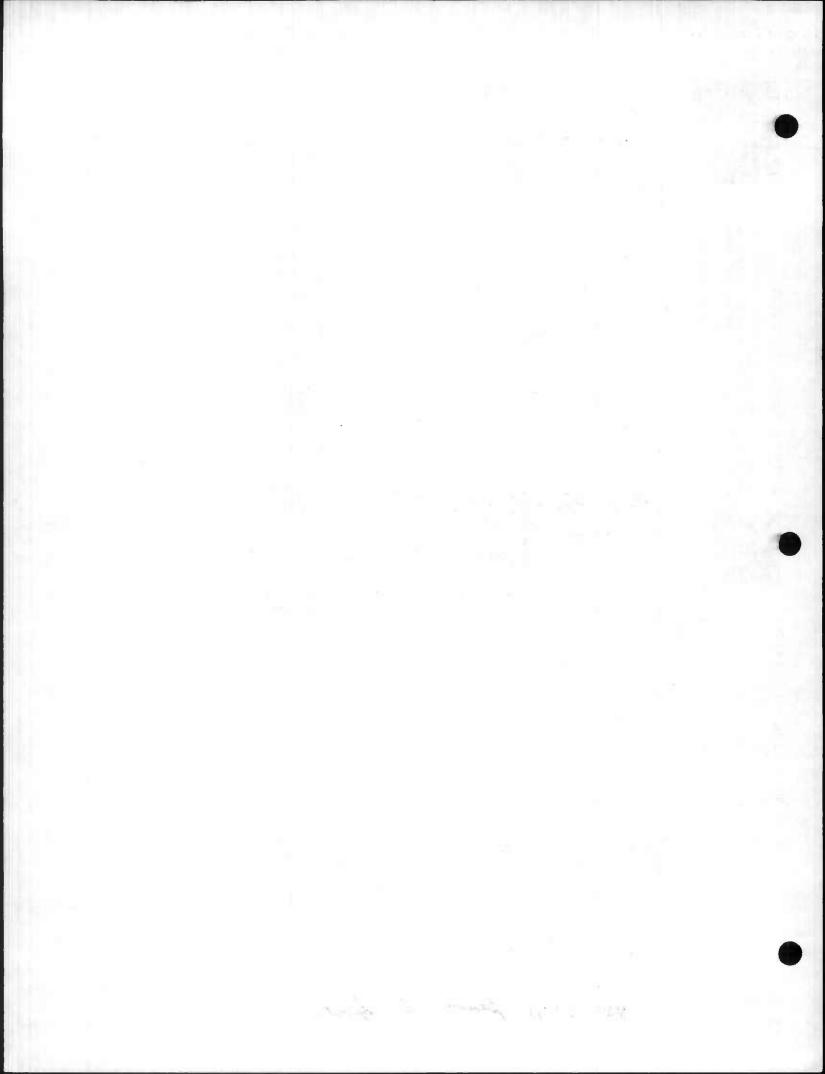
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lillian Dolores Hurd March 2, 1999 1:45 am /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corsica Hills Nursing Home Chestertown Kent 5. Social Security Number if Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthplece (Stete or Foreign Country) **Funeral** Months 1□ M 2☑ F Days Director 220-32-2437 61 Jan. 4, 1938 Kennedyville, MD Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits "natural", or items 23a or 28a-f show Director 1 Yes 2 XNo Maryland Queen Annes Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 228 Concord Road 21620 Funeral U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. nd 2 should be filed within 72 hours effer the end Mental Hygiene. 77 is marked other then "natural", or ite traumetic event, me Medical Examina ☐ Yes 2∭No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: Specify: White Be Completed by 3√ Widowed 4 □ Divorced Year or Dates: 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Book Binding Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Peges 1 and 2 should be Department of Health end Mental Important: If Item 27 is marked of any injury or other traumstic eve Lynwood Wilson Stafford 0 Lillian Addie Faulkner 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Michael C. Hurd/Son 13319 Golts-Caldwell Road, Golts, Maryland 21635 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete **Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery/March 5, 1999 Chestertown, Maryland 21. Signature of Funeral Segrice License 22. Name and Address of Fecllity reliows, Helfenbein & Newman Funeral Home, I PO Box 270, Millington, Maryland 21651-0270 Approximate ause on each line. Fellows, Helfenbein & Newnam Funeral Home, P.A. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final e. CARDIO Pulmonary Arrest

Due to (or es e consequence of): disease or condition resulting in deeth) **Examiner** Examiner Metastatic Ovarion capcinoma to operatu sician end bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Ave HB Donnon wall. P.O. Box 68760, Physician/Medical the Due to (or es e consequence of) 98 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown COPD Records, þ page 2 should Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Di Natural 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation rone 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 123889 16 30. Neme and addressed person with the second of the secon 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 948 WAShington AVE, CHE, Lentown Wed 21620 31. Date filed (Month, Dey, Yeer)

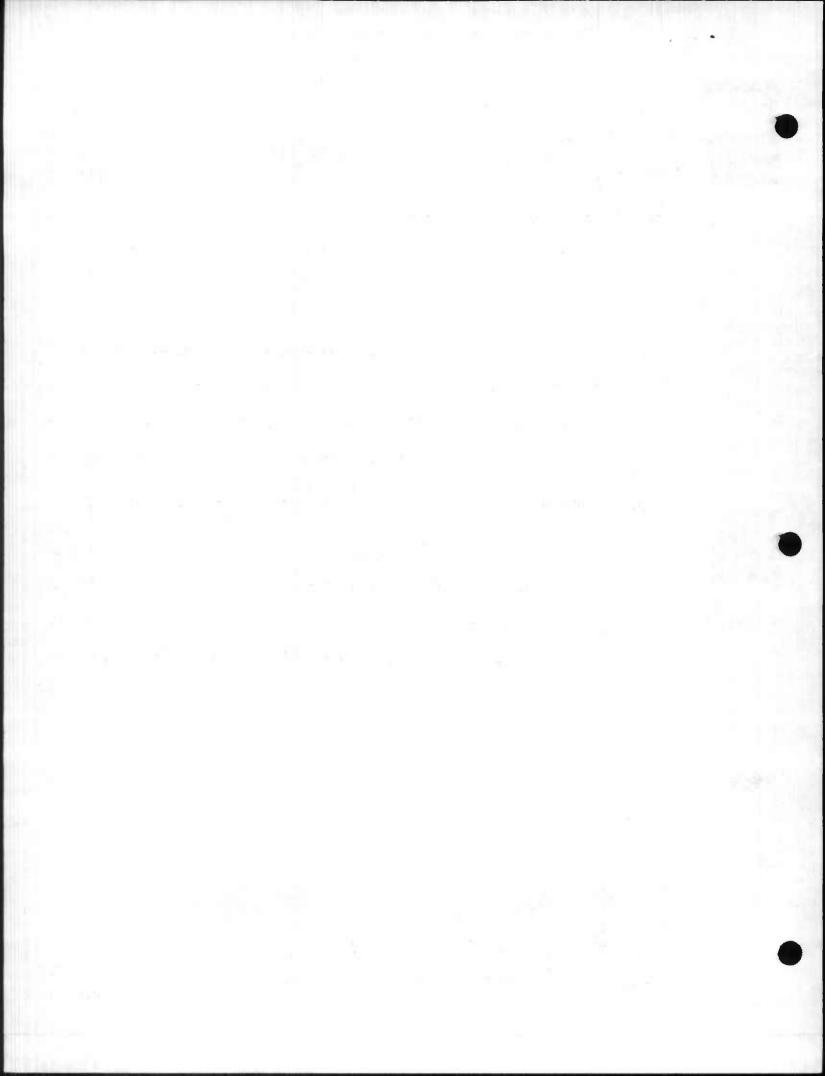
MAR 5 1999 State Registrar

DHMH 16 Bay 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of I	viaryian		iment of F ificate of	neaith and r <i>Death</i>		Reg. No.	0	8484
	Physic /Medi		1. Decedent's Neme (First, Middle, La ${ m Lofton} \ { m Elw}$		rley				2. Dete of De Month March	3,1999	Yeer	3. Time of Death 6:00 PM
	Exami		4e. Fecility Name (If not institution, giv		er)			4b. City, Town, or L Cambrid			of Deeth	-0.5
	Funeral Director		217 30 0023		Age (In yrs.		If Under 1 Year Months Deys		8. Dete of Bir (Month, De Feb 8,		9. Birthp	lece (State or Foreign try) yland
and	ž =		Usuel Residence of Decedent 10e. Stete 10b. County		10c. Cit	y, Town or Loca	tion		-		11	0d. Inside City Limits
Mary	fleds	tor	Maryland Dorches	ter	C	ambridg	e					1 ☐ Yas XXX No
2	23a or 28a-f	ai Director	10e. Street end Number 3214 Indian Bone	Road			10f. Zip Code	1613		10g. Citizen of	Whet Coun	try?
020 Surra atter des	al', or items Examiner m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yas, Giva Year or Date	s? QXVo		s Decedent of H es, specify Cubi	dispenic Origin? (Sp an, Maxican, Puerto Specify:	pecify Yas or No Rican, etc.)	14. Rac Ble Specif	e - Amaric ck, White, o	
Maryland 21215-0020	han "natur a Medical	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation de completed) College (1-40	or 5+)	(Give kir iife. DC		during most of worl d)	king	16b. Kind of B		
d 2	Hygie ther int, th	Co	10 17. Fether's Neme (First, Middle, Last,			Mai	ntenance	e Worker	e (First, Middle	State 1		tal
lan	fental fast o de eve	To Be	Samuel Lofton						Pearl H		.0,	
lary	fealth and M m 27 is man ther traumal		19e. Informent's Neme/Reletionship (Type, Print)		19b. Melling	Address (Street	end Number or Ru	rai Route Numb	er, City or Town	State, Zip	Code)
Baltimore, A	of of Health If Item 27 or other tr		Rodney P. Hurley 20e. Method of Disposition 1 Transport 2 Cremation 3 C	Removel from Ste	to C	Plece of Disposit semetery, creme	ion (Neme of tory or other ple	Bone Road	Dete	20c. Location	City or To	wn, State
Baltin permit. P	Departme Important any injury once.		4 Donation 5 Other (Specifical Signature of Funeral Service Licer		Du	22. N	Name end Addre	ess of Fecility	e, P.A.			
PI	hysician	Г	23a. Part (Inter the diseesa, or com shoot, or heart failure. List only	plications thet caus one ceusa on aech	sed the deet	- Do	44 4 1	t Street ng, such as cardiac			yland	21613 Approximate Intervel Between Onsat and Death
	Medical xaminer	16	Immediate Ceuse (Final disease or condition resulting in death)	. Sep	Due to (o	Swo	ence of):	21.5	-		- 4	rays
petn	dansit	Examiner	C	b.		or es e conseque		1115			1	ory;
0,	lotan and burial-transit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Sho		ii as a conseque	nice or).					year
x 68760,	g phys as the	Medical	Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	. Sen	Due to (or	r es a conseque		i apri	ome	uries	-5	lays
Box	attending for use a	cian										
P.O	signed by the attendin d be detached for use	by Physician/M	Part II. Other significant conditions of	ontributing to death	but not resi	ulting in the und	erlying cause giv	ven in Pert I.		Yes 2 ANO		the cause of death?
Records,	2 5 5	Completed b								en eutopsy ormed?	COL	ere eutopsy findings eileble prior to appletion of cause deeth?
E E	ate h	Com							10	Yes 2 No	10	Yes 20 No
of Vital	s certificate diractor, pag	Be	25. Wes case referred to medical axeminer?	Hospital:			0"	26. Place of Dea	th (Check only o	one)		
Of Physics	ig ig	- To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpe		ER/Outpetient 28b. Time of	3□ DOA Oth	ALL Nursing He		dence 6 Oth)
Division or Attanding	within 24 hours aftar death. To the Funeral Director: After completely filled in by the funer	Certification:	5 Pending investigation Accident Suicide Could not be determined	(Month, i	Dey Year)	Injury		rk? Yes 2□No		Street end Numl		l Routa Number,
] Hospital	within 24 hours after deat To the Funeral Director: completaly filled in by the	edical Ce	29a. Certifier (Check only one) 1 CertifyIng Ph	yelclen: To the be- niner: On the basis end mennar	of examinat	wledge, deeth o tion end/or inves	ocurred et the tir stigetion, in my o	me, dete end plece, ppinion, death occur	end due to the red et the time,	cause(s) and madete end plece,	anner as st and due to	ated. the cause(s)
To the	Within To the comp.	Me	29b. Signature and title of certifier	//	_		29c. Licans	509X	7	29d. Date signe March		
			30. Name and eddress of person who.	completed cause of	f death (Item	23a) (Type, Pri	Aura	ora,	sive	CF C	mb	moz1613.
	Sta	ite	31. Dete filed (Month, Dey, Year)	32. Regi	strer's Signe	ture	/					110/1613.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death 27, 1999 **Physician** February 1:00pm James Earl Jenkins /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 712 Downs Dr. Silver Spring Montgomery ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. lest birthday) **Funeral** M 2DF 197-18-3334 Yrs. 72 November 9, 1926 Pennsylvania Director Usual Residence of Dacedent the Marylend 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Montgomery Silver Spring 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 712 Downs Drive 20904 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amarican Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status IX Yes 2 No 1951
If Yes, Give
Year or Dates: 1953 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. Program Manager Federal Government 12 permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: If Itam 27 is marked othe any injury or other traumatic svent, bhts. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Anne Bullock James Earl Jenkins 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Dr. Maxine Jenkins (Spouse) 712 Downs Dr. Silver Spring, MD 20904 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cramation 3 Removal from State Fort Lincoln Cemetery 3-5-99 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi 11800 New Hampshire 21 Signature of Superal Service Licenses Avenue Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha moda of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final NEPHROPATIA IABETIC Cher disaase or condition resulting in death) Examiner Due to (or as a consequence of) Examiner that the death certificate be executed physicien end the buriel-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 88 USB signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? Assetes Mellitus, Insula dopondens 1 ☐ Yss 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Ronary Britery Disens y parteus in 1 Yas 2 No 1 Yes 2 No Division of Vital

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funeral After ector: A

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To

Certification:

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3

24 hours after Funeral Dire letaly filled in b after ò

To the Hosp within 24 hor To the Fune completely fi

D

25. Was case referred to medical examiner? 1 Yas 2 No

27. Menner of Death

5 Pending investigation 1 Netural 2 Accident 6 Could not be determined 3 ☐ Suicide

4 - Homicide 29a. Certifier

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

26. Piece of Deeth (Check only one)

28d. Describe how injury occurred

Other: 4 Nursing Home Besidanca 6 Other (Specify)

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and mannar stated. ettie of certifier 29c. Licensa number

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

28c. Injury et Work?

29d. Data signad (Month, Dey, Year)

11161 New HAM SCHNASP mo TERAMÓ VL

31. Date filed (Month, Day, Year)

(Check only one)

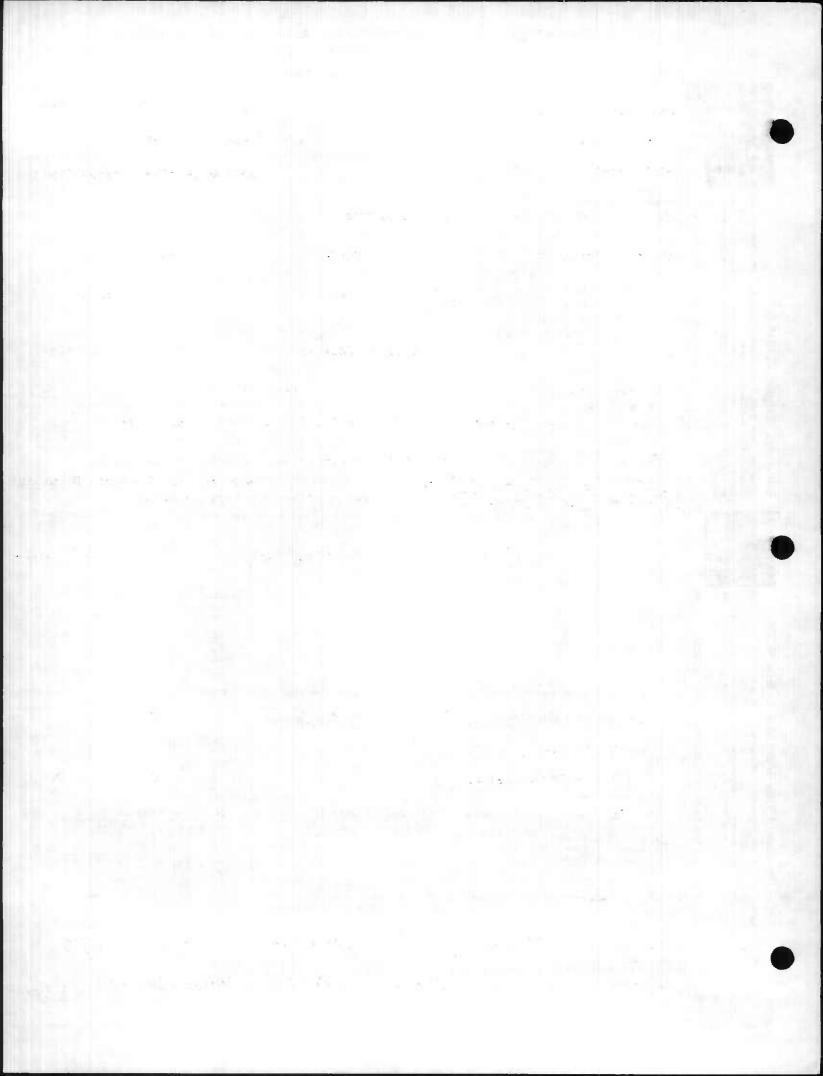
29b. Signature ap

MAR 03

32. Registrar's Signature

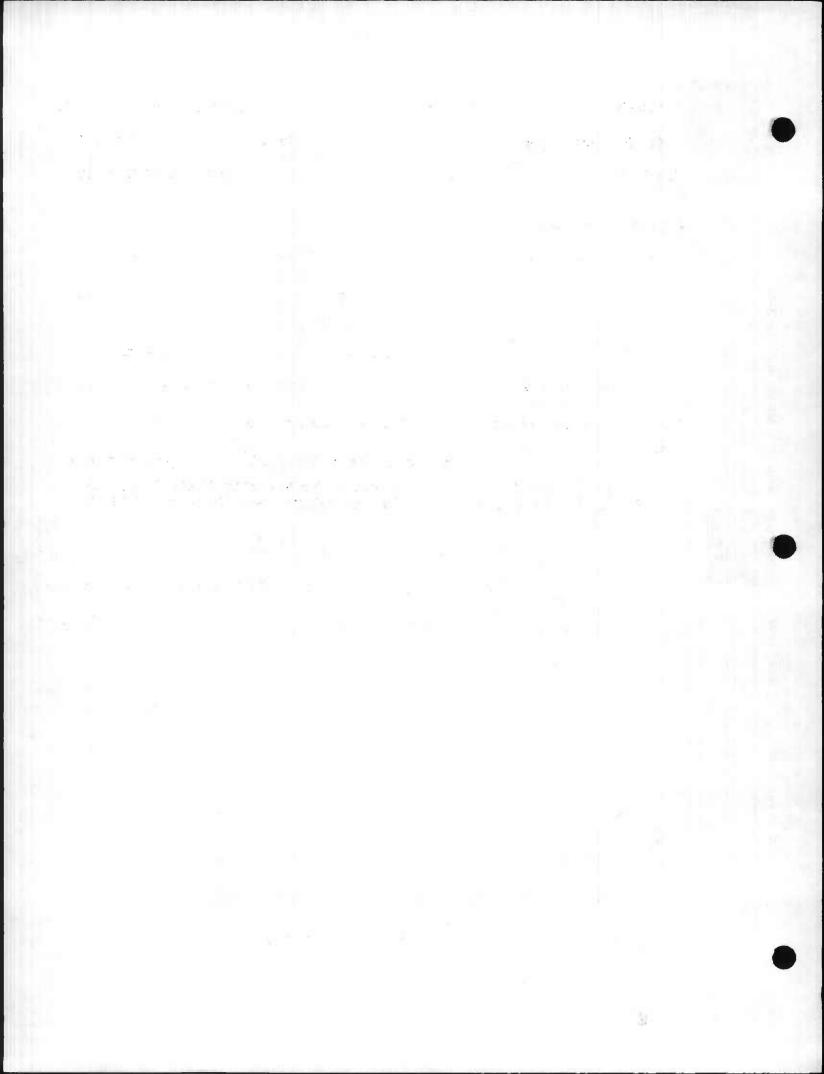
Registrar

Attanding



State of Maryland / Department of Health and Mental Hygiene 0 081.86

						Ce	ertificat	e of	Death		Re	g. No.	Us	0400
			1. Decedent's Name (First, Middle, I	Last)							2. Date of Death		V	3. Time of Death
	Physicia		VIRGINIA	MAY	JOHNS	SON					March 2,		Year	1615
٧.	/Medic Examin		4a Fecility Name (If not institution, g	ive street and num	ber)				4b. City, Tov		ocation of Deeth	4c. County of	of Death	
4		•	1413 Old Joppa	Road					Joi	ppa		F	Harfo	ord
	Funeral			. Sex	7. Age (In yrs	. last birthday	/ If Unde		r If Under 2		8. Date of Birth (Month, Day,	Voorl	9. Birthp	lace (State or Foreign
L	Director		220-62-2017 Usual Residence of Decedent	1□ M 2□xF	92	Yrs.	Months	Days	Hours	IVIII.	Sept.13,		Mary]	
	/lend		10a. State 10b. County		10c. C	ity, Town or L	ocation						1/	0d. Inside City Limits
	Man	to	Maryland Harfor	h		Joppa								1 ☐ Yes 2€ No
	r 28	Director	10e. Street end Number			Ochles	10f. Zij	Code			10	g. Citizen of W	hat Coun	try?
	h wit	0	1409 Old Joppa	Road					2108	5		USA	A	
	deat	Funeral	11. Maritai Status	12. Wes Deced		J,S. 13	. Was Dece	dent of	Hispenic Orig	gin? (Sp	ecify Yes or No- Rican, etc.)		- America	en Indien,
21215-0020	ges 1 end 2 should be filed within 72 hours effer death with the Maryland tof Heelth and Mentel Hygiene. If frem 27 is merked other than "natural", or frems 23a or 23a-f show or other traumetic event, the Medical Examinat must be notified at	P	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		2 No		1 Yes			, 1 0010	moun, etc.)	Specify:	Talle	nite
2-0	72 ho	Completed	15. Decadent's (Specify only highest of			16a. Dec	edent's Usu	al Occu	pation during most	of work	ring 1	6b. Kind of Bus	siness/Inc	Justry
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	or th	Con	8			Hon	nemake	r				Own Hon		
pu	ould be filed with Mentel Hygiene. arked other than etic event, I'm	Be	17. Father's Name (First, Middle, La	•							e (First, Middle, M		s)	
yla	Ment Ment	2	John Thomas Gur	ther					Edn	a M	May Tim	nons		
Maryland	2 should and Men Is merke		19e. Informent's Name/Relationship	(Type, Print)		19b. Mei	ling Addres	s (Stree	at and Numbe	r or Run	rel Route Number,	City or Town, S	Stete, Zip	Code)
	1 end 1 Heelth em 27		Viola M. Hughes/	Sister					ia Rd.	, Jo	oppa, MD			
Ore	Per Int		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	☐Removei from S		Place of Disp cemetery, cr	ematory or	me of other pl	ace)	1	Date 2 3-5-99	Oc. Location - 0	Olty or To	wn, State
Ξ			4 Donation 5 Other (Spec			inity	Luthe	ran	Chr.	Cern.	-3-99	Joppa, M	Mary.	Land
Baltimore,	permit. Departminents any injury inju		an Signature of Funeral Servica Lic	AM A		F	22. Name a	nd Addi	McCom	y as 1	III Funer	al Home	e. P	.A.
	40 = 6 a		Alle .	11 Klon	104	1	317 C	oke	sbury	Road	d, Abingo	don, MD		
			23e. Pert1. Enter the disease, or co shock, or heart full ra. List on	mplications that ca	used the dea	th. Do not e	nter the mo	de of dy	ring, such as	cardiac	or respiratory erre	st,		Approximete Intervel Between
Y	Physician			a	1		01.	. 1		A		_ /		Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	. (2	reb	10 Va	Su	111		H	ccid	ent		48 hours
L	·		resulting in death)	^	Due to (or as a cons	equence of)		,	0 0	1.	- 0 /	1/	1
	sit ad	edical Examiner		b. Ar	ter	7080	ler	ot	re (M	dion	2 Scula	1 de	D >10 yrs
ď	eath certificete be executed etending physician end for use as the bunel-trensit	хап	Sequentially list conditions, if any, leeding to immediate	11	Due to (or es a conse	equence of)							
68760,	be e lcian burie	a le	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	c. H	per	ten	Sur	\sim					1	>10 yrs
387	phys the	dic	that initiated events resulting in death) Lest	/	/ Due to (or es a conse	equence of):						1	
×	ding ise e	2		d										
8	etter for u	Clar									T			
o.	the d	Physician	Part II. Other significant conditions	contributing to dea	ath but not re	sulting in the	underlying	cause g	iven in Part I.			V.		the cause of death?
J.	thet the death ce led by the ettendi										1 Ye	s 2 No	3 Prol	bably 4 Unknown
Records,	v requires thet the death c been signed by the ettend should be deteched for us	Completed by									24a. Was ar perform		av	ere autopsy findings allable prior to mpletion of ceuse
ec	≥ s C S	pje											of	deeth?
	는 음성	5									1 □ Ye	s 2 000	1 [Yes 2 No
Vita	Physician: The rthis certificate aral director, pag	Be	25. Was case referred to medical examiner?							of Deet	th (Check only one	9)		
of	5 00	2	1 ☐ Yes 2 No	1		ER/Outpati		DA		rsing Ho	ome 5 Reside			V)
-	fler the	on:	27. Menper of Death 1. Natural 5 Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time injury		28c. Inj W			28d. Describe ho	w Injury occurre	ed	
Sio	Attending or death.	cati	2 ☐ Accident Investigat	ho			М		Yes 2 1	No				
Division	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not 4 Homicide determine	ad 286. Place	of Injury - At I g, etc. (Spec	nome, farm, s ify)	treet, factor	y, office	Ð		28f. Location (Str City or Town	reet and Numbe , Stete)	r or Rura	il Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direction pletely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying I	Physician: To the la aminer: On the ba end menn	sis of examin	owledge, dea ation and/or i	nth occurred investigation	at the	time, date an opinion, dea	d place, th occur	end due to the ca red et the time, da	use(s) and mai ite and placa, a	nner as s ind due to	tated. the cause(s)
	o the	Me	29b. Signeture and title of certifier	20	1	. 0	29	c. Lice	nse number	^	25	ed. Date signed	(Month,	Day, Year)
	- s - ŏ		Killer	KSma	eas	ress	1	44	058	2				
	α		20 Name and address of account	o completed	of dans no	m 22=\ CC.	Deint)	17	1	4 /		1 4		
			30. Name and address of person who		OVE (Ite	2021	EMI	na	Hon	RO	Ste 114	Bel	Hir	Md 21015
	Sta	te	31. Date filed (Month, Day, Year)	≱ 2. Re	gistrar's Sign		1				- 1 - 1			
	Daniel and		888D 4 1000	1 Fren	rough	17	Ann	15						



Gilbert Johnson

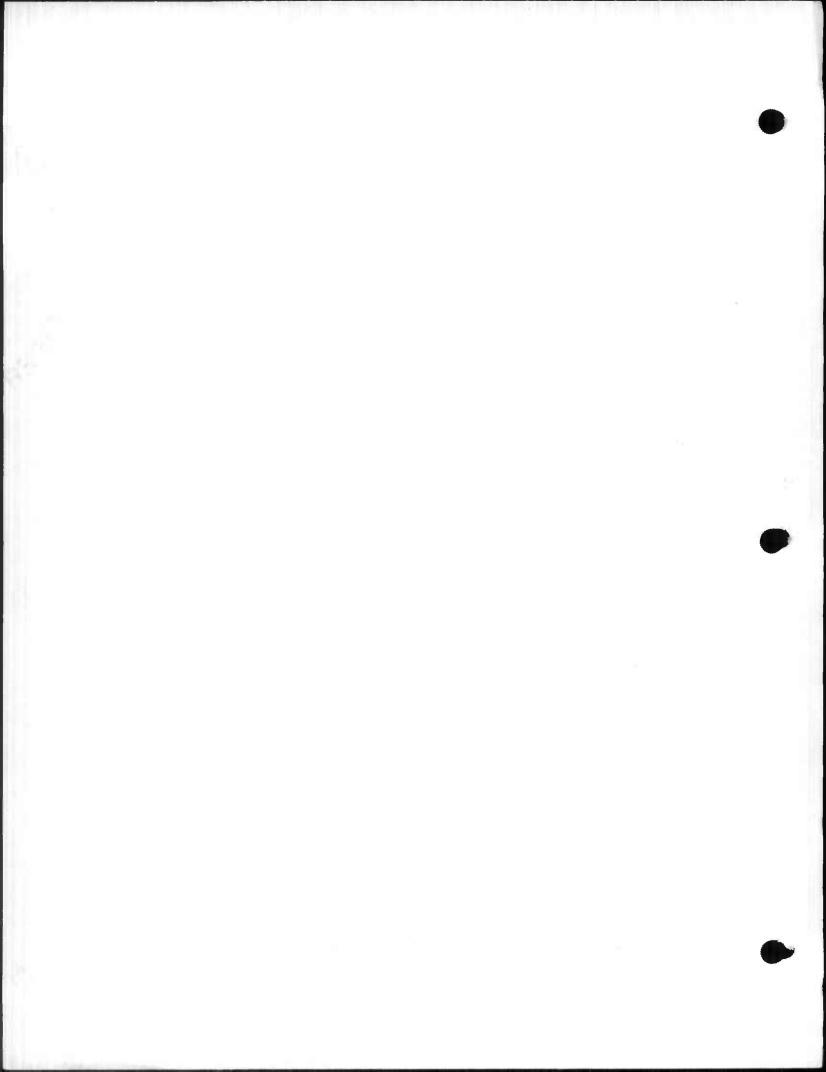
JAMES GIBERT

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

1 - STA	ISTRAR		CE	RTIF	CATE C	F DEATH	D MEN	REG. NO.	_			
1. DECEDE	ENT'S NAME (First, Middle, Last)							ATE OF DEATH			3. TIME OF DEATH	
Jam	les	Gilbert			Johns	on		irch 5.	ຶ 1999	YEAR	2:06 PM W	
4. SOCIAL	SECURITY NUMBER		i. AGE (In yrs. lest	birthday)	IF UNDER 1 YE	AR IF UNDER 24 HR	RS. 7, D.	ATE OF BIRTH			PLACE (State or Foreign	
217-	14-8656	1 M 2 🗆 F	89	YRS.	MONTHS DA	YS HOURS MIN		fonth, Day, Year)		Countr	vland	
	TY NAME (If not institution, give a	treet and number)	00		9b. CITY, TOV	VN OR LOCATION OF		03/ 1303	9c. COUN			
Mano	kin Manor Nur					ess Anne			Somerset			
10e. STATE		Y		10c. CITY	, TOWN OR LO	CATION					10d. INSIDE CITY	
Mary!	land Some	rset		Pri	incess	Anne				LIMITS?		
	ET AND NUMBER			1 4 4	LITECOO	10f. ZIP CODE			10g, CITIZ	EN OF W	THAT COUNTRY?	
100. STREE	O Pruitt Lane					21052						
11. MARITA		12. WAS DECEDENT	EVER IN U.S.ARM	21853 ARMED 13. WAS DECENDENT OF HISP			SPANIC OR	IGIN? (Specify Yee	or No		— American Indian.	
	r Merried 2 Merried	FORCES? 1		NO If yes, specify Cuben, Mexic 1 □ YES 2/2 NO Specify			xican, Pue	rto Rican, etc.)		Specia	, White, etc.	
Elemen	15. DECEDENT'S EDU	CATION	16a, DEC	EDENT'S I	USUAL OCCUE	ATION		16b. KIND OF BUS	INESS (IND)	ICTOV	White	
Flores	(Specify only highest grade tary/Secondary (0-12)		(GM	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				IOD. KIND OF BUS	MACSS/MDC	Joint		
	9	College (1-4 or 5+)	Tues	ugBoat Captain					-			
17. FATHER	I'S NAME (First, Middle, Last)		Liuur	ouat	Capta		NAME (C)	Marine rsi, Middle, Melden		spor	rtation	
	ge W. Johnson	0					Section Williams	Surname)				
100 INFOR	MANT'S NAME (Type/Print)		100	MAR INC	4.000.00 (O)	PIGICE I		Daniels				
		ocen/Deugh										
200 METH	llis A. Parki	ison/ baugr	iter 26	914	Mt. Ve	ernon Roa		rincess	Anne	<u>, Mc</u>	1. 21853	
Burle	OD OF DISPOSITION	oval from State	20b. PLACE AN cometery, crem ASDUTY	nd DATE O	F DISPOSITION her place)	(Name of	1	DATE 20c. LOCATION — City or Town, State				
The state of the s	tion 5 Other (Specify)	ENGEE	ASDUTY	<u></u>		E AND ADDRESS OF	3/	8/99 M	t. Ve	rnor	. Maryland	
1/1	27	7	`			nan Funer						
The	nusia. K	Urnin	/ M0029	15					inces	e An	ne. Md. 218	
disease	shock, or heert failure. TE CAUSE (Final or condition in death)			Semuence of	ule I	Pemente	a, A	lyleime	20 /2	jre	Interval Between Onset and Daath 2 4/4	
if any, le cause. E CAUSE (I that initio	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inflieted events resulting in death) LAST											
PART II.	Other algoriticent condition Calculation Securitical OBACCO USE CONTI	2 fun	eun	usi	ia.	Dysple	agi	24a. WAS AN / PERFORI	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO	
	SE REFERRED TO MEDICAL	MIDDIE TO CAO			H (Check only o		AII1					
EXAMII 1 7	NER? ES 2 X NO	HOSPITAL:			OTHER:							
	R OF DEATH	28e. DATE OF IN		28b. TIME		INJURY AT						
1 N Na 2 Ac	tural 5 Pending	(Month, Day,	Ybar)	INJU	IRY	WORK?	280.	DEŞCRIBE HOW IN	IJURY OCCU	JRED		
2 Ac 3 Su 4 Ho	o Codin tint be	28e. PLACE OF I building, etc	reet, factory, o	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				oute Number,				
29e. CERTII (Check one)		CIAN: To the beet of m	r knowledge, deat	th occurred	at the time, o	late end place, end on, death occured at	due to the	cause(e) end mend lete and place, and	ner as stated	i. causo(e)	and menner ee stated.	
29e. CERTII (Check one)	TURE AND TITLE OF CENTY IER	100 00		7 -		29c. LICENSE I	NUMBER		29d. DATE	SIGNED	(Month, Day, Year)	
	geris la.	Bello	22 1	47	?	D 29	505 3-8					
1100	SORIO M. BE											
31. DATE FI	LLB (INDINIT, Day, 1001)	ELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, Mp. 2180								, 21001		
	MAR 1 0 199	9 Sens	va /	9.	Spar	Kel						



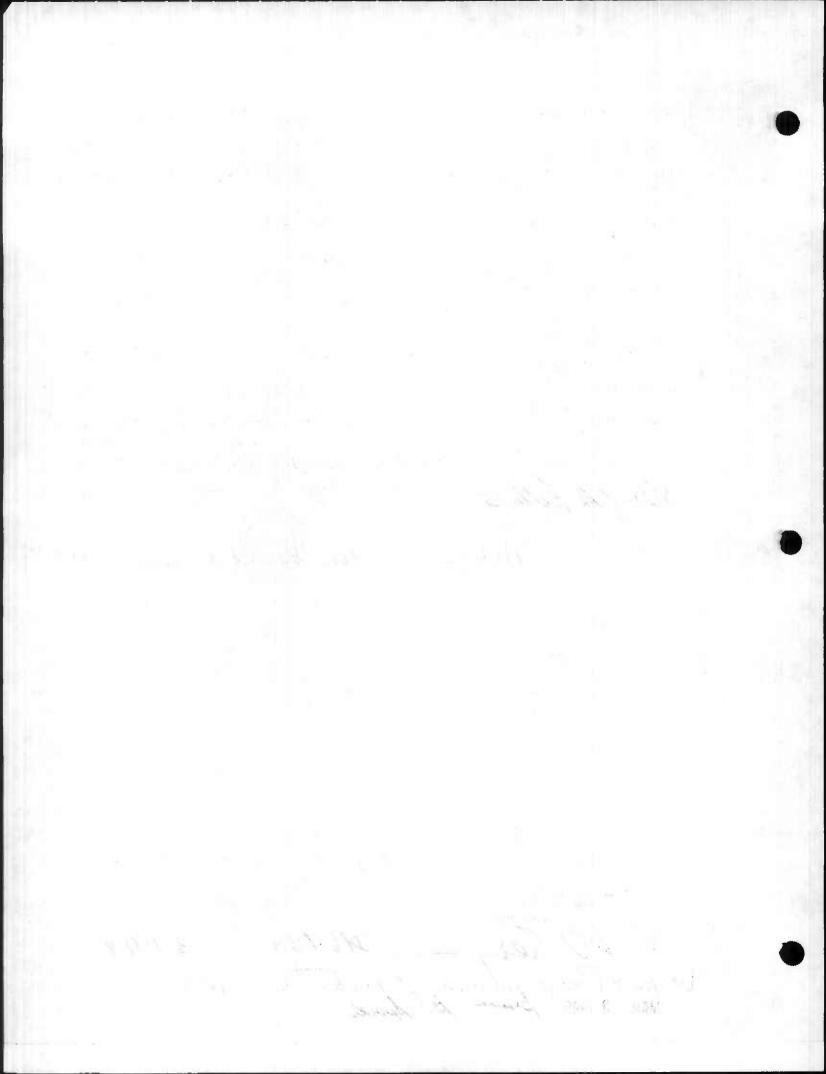
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3 Time of Death **Physician** Month Day 25, CORA LUCINDA JONES FEBRUARY 1999 20:16 /Medicai 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S HOSPITAL KENT AND CHESTERTOWN 5. Social Sacurity Numbar If Undar 1 Yaar if Under 24 Hrs. 8. Data of Birth (Month, Day, 7. Aga (In yrs. last birthday) **Funerai** Birthplaca (State or Foreign Country) Months Days Year) 1 M 2 XF 62 214-34-6041 Director August 21, 1936 Crumpton, MD Usual Rasidance of Dacedant 10a, Steta 10b. County 10c. City, Town or Location 10d. insida City Limits Director 1 X Yas 2 □ No Maryland Queen Annes Crumpton 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 330 Broad Street 21628 by Funeral U.S.A. 14. Race - Amarican Indian, Biack, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxican, Puarto Rican, atc.) I ☐ Yas 2 ☒ No It Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 X No Specify: Specify: 3 Widowad 4 Divorced White Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) Housekeeper Cleaning 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Benjamin Glanding Mary Lucinda Reed 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Miller/Daughter PO Box 124, Crumpton, Maryland 21628 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata N Buriai 2 ☐ Cramation 3 ☐ Ramovai trom Stata 4 ☐ Donation 5 ☐ Othar (Specify) Crumpton Cemetery/March 1, 1999 Crumpton, Maryland Fellows Address Enbein & Newnam Funeral Home, P.A. PO Box 270, Millington, Maryland 21651-0270 nons that causad tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, causa on each line. **Physician** Probable Suddy Cardine /Medical Immediete Causa (Final disaasa or condition rasulting in death) Examiner Dua to (or as e consequanca of). The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in daath) Last and use as the buriel-tran Due to (or as a consaguance ot): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Dua to (or as a consequence of) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ✓ Yes 2 □ No 3 □ Probably 4 □ Unknown Smykn þ Completed 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy parlormed? Levamin is certificate hes 1 Yes 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 26. Pleca of Daath (Check only one) Othar: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this In by the funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Tima ot 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural death. 1 ☐ Yas 2 ☐ No 2 Accidant efter death 6 Could not be datarminad 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 4 Homicide the Hospital within 24 hours of To the Funeral I 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and piece, and due to the cause(s) end mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and mannar stated. Medicai 29a, Certifian completely 265. Signature and little of certifier 29c. Licansa numbar 29d. Data signad (Month, Day, Year) 100 6 30. Nema and eddress of person who complated causa of daath (Item 23e) (Typa, Print) Spean RD 120 32. Registrar's Signatur 31. Data tilad (Month, Day, Yeer) State 3 1999 MAR Registrar

while Middle was in the state of the s

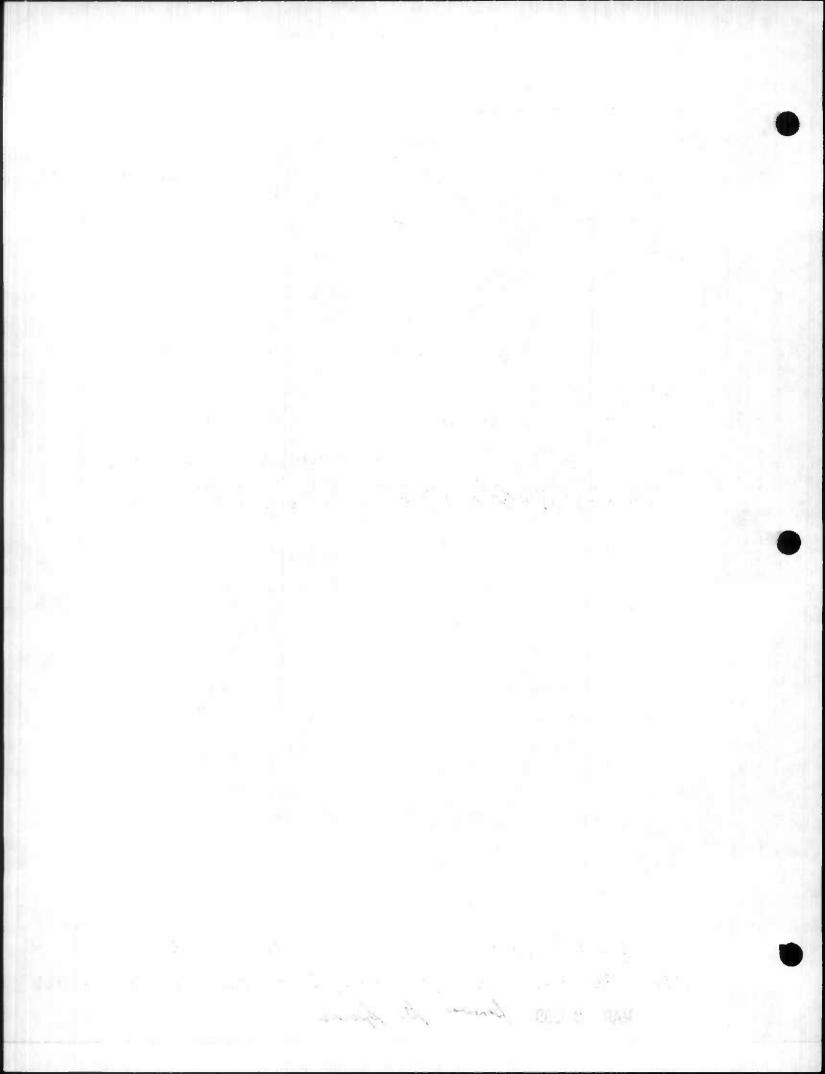
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Q 1, Q Q

			Certifi	icate of	Death	R	eg. No.	00409
	Physic	ion	Decedent's Name (First, Middle, Last)			2. Data of Deat Month	-	3. Time of Death
U	/Medi		Howard Edward Jester			Februar		999 5:40 pm
A	Exami	ner	4a. Facility Name (If not institution, giva street end number)		4b. City, Town, or Lo		4c. County of	of Death
L			Thompson House	U. I. A.V.	Church H		Que	en Annes
П	Funeral Director		MON 2015	Under 1 Year onths Days		8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
		1	213-16-7803 Residence of Decedent			Nov. 17	, 1914	Hayden, MD
	yland		10a. State 10b. County 10c. City, Town or Location	n				10d. Inside City Limits
	e Ma	ctor	Maryland Queen Annes	St	udlersvil	le		1 No 2 No
	1 So 1 S	Director	10e. Street and Number 10	Of. Zip Code		10	g. Citizan of W	het Country?
	23°	ra	133 W. Main Street	2:	1668		U.S.A	.•
	er de	Funeral	11. Maritel Status 12. Was Decedent Ever In U,S. 13. Was I Armed Forcas? 13. Was I If Yes	Decedent of to, specify Cub	Hispanic Origin? (Speen, Mexican, Puerto	ecify Yas or No- Rican, etc.)		- Amarican Indian, k, White, etc.
20	72 hours after death with the Maryland naturel', or items 23e or 28e'f show dical Examiner must be notified at	by F	1 Navar Married 2 Married NAVYes 2 No If Yes, Giva 1 Yes rough Transfer Turner	as 3ENo	Specify:		Specify:	
9	ture E		3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWT ☐ 15. Decedent's Education 16e. Decedent's	Lieual Occur	netlon		6b. Kind of Bus	
215	hin 72	Completed	(Specify only highest grede completed) (Give kind life, DO N		during most of work	Ing	TOD. INITIA OF BUS	messindustry
21	d with	mo:		eighmas	ster		Agric	culture
nd	ei Hy ei Hy othe	Be	17. Father's Name (First, Middla, Last)		18. Mothar's Name	e (First, Middle, M		
yla	Ment Ment arked	2	Samuel Jester		Bessie M.	Tarbut	ton	
Jar	2 sh end ls m				end Number or Run			
6,	fealth m 27 her t							yland 21668
Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health end Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or fisma 23e or 28a-f show any fijury or other traumetic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 20b. Place of Disposition cemetery, cremetory	y or othar pla	ce)]	1999	Oc. Location - C	City or Town, State
Ħ	it. Partmer		4 Donation 5 Other (Specify) Sudlersville 21. Signatur & Funeral Service Licensar 22. Nan			1 4, S1	ıdlersv:	ille, Maryland
Ba	Depemination of the population		Follow Follow	TT.	elfenbein	& Newnar	n Funera	al Home, P.A.
_	-		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	Box	270, Milli	ngton, l	Maryland	d 21651-0270
u	Dhuelaian		shock, or heart failure. List only one ceuse on each line.	mode or dyl	ng, such as cardiac (or respiratory arre	St,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Ceusa (Final		Ren			Orisot and Doath
н	Examiner		disaase or condition resulting in death) a. The world and a condition and a condition and a condition and a condition and a condition and a condition		- Ken	A de	reres	e Yrs
	D #	ner	Dua to (or as a consequence	a 01):				
	law requires that the death certificate be executed as been signed by the ettending physician and a 2 should be deteched for use as the buriel-transit	Examiner	Sequentially list conditions, Due to (or as a consequence	e of):				
30,	sian a		Sequentially list conditions, if eny, leading to immadiate cause. Entar Underlying Cause (Disease or Injury					
68760,	ohysic the t	Medical	that initiated avants resulting In death) Lest Due to (or as a consequence	a of):				
ox 6	ding I		d					
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o.	y the	Physician/	Part II. Other significent conditions contributing to death but not resulting in the underly	ing causa giv	en in Part I.			tribute to the cause of death?
S, P	v requires that the death or been signed by the ettend should be deteched for us	by Pt				1 🗆 Ye	\$ 2□ No	3 Probably 4 Unknown
rds	quires n sign					24a. Wes er	eutopsy	24b. Ware autopsy findings
Record	w rec	ojet				perform	ed?	available prior to complation of cause of death?
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Vital	certificate rector, pag	BeC	25. Wes case referred to medical		28. Place of Deeth			1 1 1 1 1 2 1 1 1 0
>	Physician: r this certific	10 8	examine ? 1 Yas 25 No Hospitel: 1 Inpatiant 2 ER/Outpatient 3	DOA Oth	Mari	ne 5 Rasida		r (Specify)
TO L	ding Ph h. After th funerel		27. Manner of Death 1 Nature 5 Pending 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury	28c. Injur		28d. Describe ho		
0	Attending or death.	atle	2 ☐ Accident Investigation M		Yas 2 □ No			
Division	i or Attendin efter death. I Director: Af d in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be detarmined 28e. Place of Injury - At homa, farm, street, fe building, afc. (Specify)	ectory, offica		28f. Location (Str. City or Town,	eet end Number State)	r or Rural Routa Number,
	Hospital or 24 hours efter Funeral Dir Nely filled in							
	To the Hospital o within 24 hours of To the Funeral Di completely filled in	edical	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one)	irred et the tin ation, In my o	ne, date and placa, a pinlon, death occurr	and due to the ce ed at the time, da	use(s) and men le end place, ar	ner as stated. nd due to the cause(s)
	within 2 To the	X	29b. Signature and title of cartifi	29c. Licans	a number	29	d. Data signed	(Month, Day, Yeer)
	->-0		1. 00 (0)	D/6	433		3-1-0	0 -
			30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)		1			(/
	2	5+1	utione & Senjamin M.D. Ch	este	r TOINI	m		
	Sta		31. Dete lied (Month, Day, Year) 32. Registrar's Signature	1.				-
	Registra	16	אחנונו יין ייטטי אוחנונו	des!				



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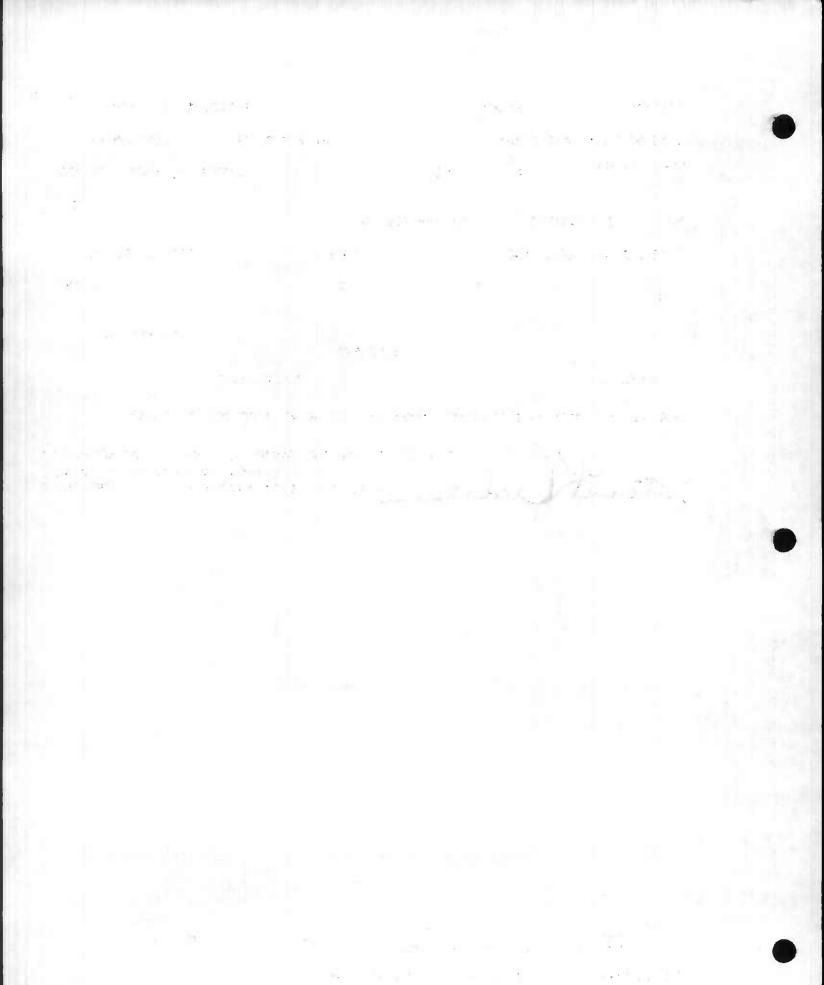
No. of Contract	Y	1. Decedent's Name (First, Middle, Last)						2. Dete of De	ath		3. Time of Dee
Physic		Charlotte Patricia	Ichnaco					Month	Dey	Yeer	100
/Medi Examir		4e. Fecility Neme (If not institution, give s					4b. City, Town, or	Februa:			3:00 a
EĂdiiii	net	11320 Lynch Road	,	,			Lynch		Kent		
Funeral		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under						8. Dete of Bir		_	iece (State or For
Director		222-12-9302	Iм 2ХОХF		Yrs.	Months Deys	Hours Min	8. Dete of Bir (Month, De May 21	, 1929	Penn	elece (State or For stry) sylvania
tal tygiene. d other than "naturel", or items 23a or 28a-1 show event, tra Medical Examinar must be notified at	J.	10a. State 10b. County		10c. City, To						1	0d. Inside City Llr
288-	ect	Maryland Kent 10e. Street end Number		1	Jynch						
0 8	ក់					10f. Zip Code				tizen of Whet Country?	
8 23	era	11320 Lynch Road	2. Was Decedent	Frontin III C	40.146	2164			USA		1 6
iene. r than "naturel", or thems 23a or 28a-f show tre Medical Examinar must be notified at	by Funeral Director	11. Marital Stetus 1 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces: 1 Yes 2 If Yes, Give Year or Detes:	Populario (S.)		Yes, specify Cubi	dispenic Orlgin? (S an, Mexican, Puer Specify:	opecity Yes or No to Ricen, etc.)	Specify	e - Americ ck, White, /: Wh:	
of the last	ted	15. Decedent's Educ	eation	166	e. Decede	ent's Usuel Occup	petion	dila i	16b. Kind of B	usiness/Ind	dustry
Man.	Completed by	(Specify only highest grede Elementary/Secondary (0-12)	Completed) College (1-4or	5+)			during most of wo d)				
Hygiene. other than	Com	10		H	Iomem	aker			Own Ho	ome	
d othe	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Suman	10)	
	ToE	Raymond Holland Cl	ark				Sara En	nily Pri	ce		
and Mer Is marke aumetic	-	19e. Informent's Neme/Reletionship (Typ	oe, Print)	19	b. Meiling	Address (Street	end Number or R	urei Route Numbe	er, City or Town,	Stete, Zip	Code)
들다크		Raymond Clark John	son, Sr.								·
		20e. Method of Disposition		20b. Piace	of Disposit	tion (Neme of		Date	20c. Location -	City or To	wn, State
		1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify)	emovei from Stete			etory or other plea	1				
ntan nju		21. Signature of Funeral Service License	. /	ulesap		Name end Addre	Center, LL	5 3/1/99	Stevensy	ше,	MD
Department of Important: If IN any injury or one		1 Thus	fell	11.	Fe11	lows, Helf	enbein & N			P.A.	
	_				130	Speer Roa	d Chester	town MD	21620		
Medical		23a. Pert1. Enter the disease, or complications, or heart feilure. List only one Immediate Ceuse (Finel disease or condition resulting in deeth)			not enter	the mode of dyir		c or respiretory e	rrest,		Approximete Intervel Between Onset end Deet
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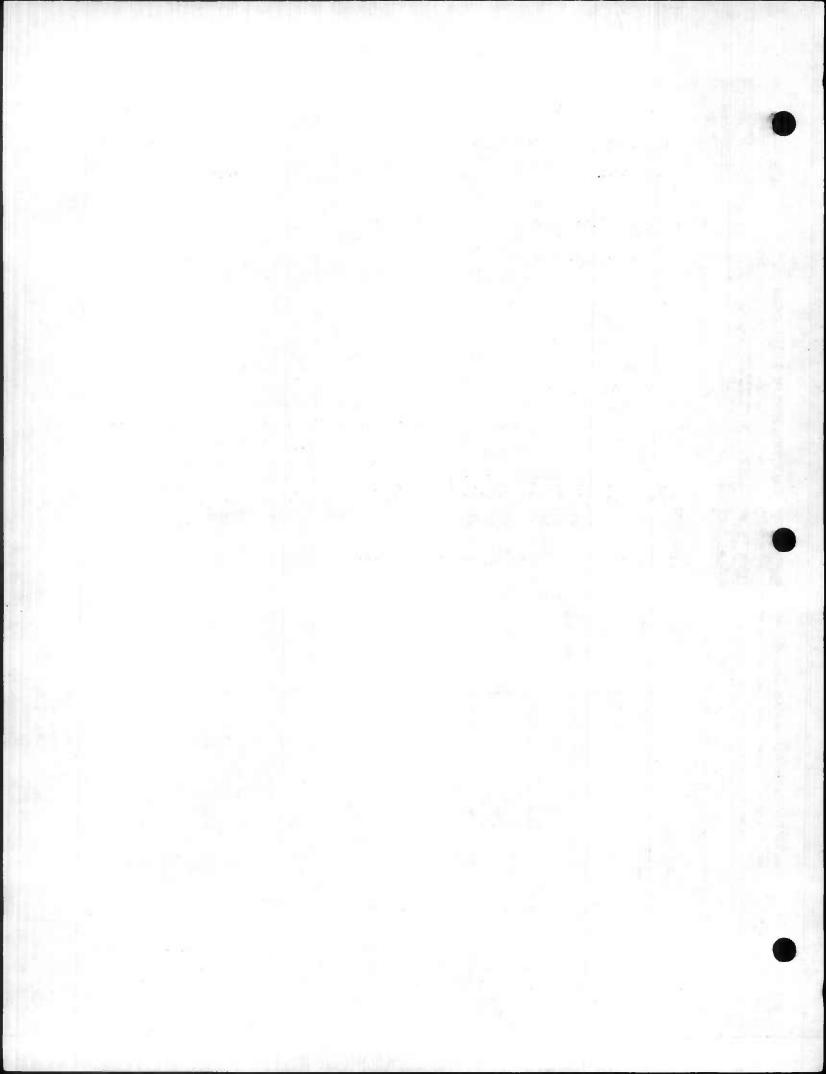
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State of Maryland / Department of Health and Mental Hygiene

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1 Several 2 Committee	George N	largarite	s / nephew				dow Road,	Rockv			2085		
21. Signature of Funeral Service Licenses M00831 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, 7577 Wisconstin Avenue, Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, 7577 Wisconstin Avenue, Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, 7577 Wisconstin Avenue, Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, 7577 Wisconstin Avenue, Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, 7577 Wisconstin Avenue, Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, 7577 Wisconstin Avenue, Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, 7577 Wisconstin Avenue, Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, 7577 Wisconstin Avenue, Bethesda, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, 7577 Wisconstin Avenue, Bethesda - Chevy Chase, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, Maryland 20814-3501 Robert A. Pumphrey Funeral Home / Bethesda - Chevy Chase, Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Home / Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral Robert A. Pumphrey Funeral			2 Demoval from State	0.000	e of Disposition etery, cremeto	n (Neme of ry or other plea	March 3	Date 1999	20c. Location - 0	City or Town,	State		
23a. Part I. Enter this disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 25a. Part I. Enter this disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 25a. Part I. Enter this disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 25a. Part I. Enter this disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 25a. Part II. Other algorithms as a consequence of): 25a. Atherosclerotic Heart Disease Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Was case referred to medical examiner? 25a. Due to (or as a consequence of): 25a. Was case referred to medical examiner? 25a. Due to (or as a consequence of): 25a. Was case referred to medical examiner? 25a. Due to (or as a consequence of): 25a. Due to (or as a consequence of): 25a. Was case referred to medical examiner? 25a. Due to (or as a consequence of): 25a. Was case referred to medical examiner? 25b. Due to (or as a consequence of): 25c. Place of Death (Check only one) 25d. Dascribe how injury occurred to the consequence of (Specchy) 25a. Date of Injury. At home, farm, street, factory office 25b. Injury of Death (Specchy) 25c. Lication (Street and Number or Faural Routa Number of Rural Routa Number of Street and Number or Rural Routa Number of Street and Number or Rural Routa Number of Street and Street and Pace, and due to the cause(s) and menner as stated and place, and due to the cause(s) and menner as stated examiner. On the basic of examination end/or investigation, in my opinion, death occurred at the time, date								, 1777	Washingt	on. Do	3		
Robert A disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areal. Approximate shock, or heart feiture. List only one cause on asch line. Approximate shock, or heart feiture. List only one cause on asch line. Approximate shock, or heart feiture. List only one cause on asch line. Approximate shock, or heart feiture. List only one cause on asch line. Approximate shock, or heart feiture. List only one cause on asch line. Approximate shock, or heart feiture. List only one cause on asch line. Approximate shock or heart feiture. List only one cause on asch line. Approximate shock or heart feiture. List only one cause on asch line. Approximate shock or heart feiture. Approximate shock or heart feiture. Approximate shock or sh	21. Signature of	Funeral Service L	icensee 0		1 22. Na	me and Addre	ss of Facility						
23a. Part I. Enter this disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, inferval Betwin Interval Betwi	Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase,												
Due to (or as e consequence of): Part II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	Sequentially list	Dua to (or as a consequence of):											
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24a. Was an eutopsy performed? 24b. Were autopsy in available prior of completion of care of death? 1 Yes 2 No 1 Y													
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25. Was case referred to medical examiner? Second Death Secon								perf					
examiner? 1 Yes 2 No										of deat	th?		
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29b. Signature and didla of certifier 29c. Liquing All Natural 29c. Liquing All Natural 29c. Liquing All Natural 28c. Date of Injury All homa, farm, street, factory, office 28c. Injury March 1 Yes 2 No 28c. Injury March 1 Yes 2 No 28c. Injury March 1 Yes 2 No 28c. Injury All Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 28d. Dascribe how injury occurred 3 Don Namber of Dascribe how injury occurred 3 Don Namber of Dascribe how injury occurred 3 Don Namber of Dascribe how injury occurred 3 Don Namber of Dascribe how injury occurred 3 Don Namber of Dascribe how injury occurred 4 Dascribe how injury o		formed to marking!					ne Diagonal P	10	Yes 2X No	of deat	th?		
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4 Homicide 29a. Certifier (Check only 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data end place, end due to the ceuse(s) and menner as stated. 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	examiner? 1 Yes 2 27. Manner of D	No eath	28e. Date of In	jury 28	b. Time of tnjury	28c. Injur Wor	er: 4 💢 Nursing H y et k?	1 ☐ th (Check only ome 5 ☐ Res	Yes 2X No one)	of deat	th?		
(Check only 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. 29b. Signature and title of certifier Patticial 29c. License number D51916 March 1, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	25. Was case re examiner? 1 Yes 2 27. Manner of D 1 Natural 2 Accider	eath 5 Pending investiga	28e. Date of In (Month, D	jury 28	b. Time of tnjury	28c. Injur Wor	er: 4 💢 Nursing H y et k?	1 ☐ th (Check only ome 5 ☐ Res	Yes 2X No one)	of deat	th?		
29b. Signature and title of certifier Patricia L. Tomsko, Md 29c. License number D51916 March 1, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	examiner? 1 Yes 2 27. Manner of D 1 Natural 2 Accider 3 Suicide	eath 5 Pending investige 6 Could no	28e. Date of In (Month, D) ation of be need 28e. Place of It	jury (28)	b. Time of tnjury	28c. Injur Wor M 1	er: 4 💢 Nursing H y et k?	th (Check only ome 5 Res 28d. Dascribe	Yes 2X No one) idence 6 □Othe how injury occurre	of déal 1 □ Ye or (Specify) ed	th? es 2⊡ No		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	25. Was case re examiner? 1 Yes 2 27. Manner of D 1 Natural 2 Accider 3 Suicide 4 Homick 29a. Certifier (Check only one)	S Pending investige 6 Could no determin	28e. Place of le building, e	njury - At home etc. (Specify) t of my knowled of examination	b. Time of trijury	28c. Injur Wor M 1 1 factory, office	er: 4X Nursing H y et k? Yes 2 □ No ne, date end plece, pinion, deeth occur	th (Check only ome 5 Res 28d. Dascribe 28f. Location City or To	Yes 2X No one) idence 6 □Other how injury occurre (Street and Number win, Stete) a ceuse(s) and mer date and place, a	of deal 1 Ye or (Specify) ed or or Rurel Ro nner as states ind dua to the	th? es 2□ No outa Number d. a cause(s)		
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Patricia L. Tomsko, M.D. 11140 Rockville Pike, #348, Rockville, Maryland 20852	25. Was case re examiner? 1	eath 5 ☐ Pending investige 6 ☐ Could not dee ☐ Could not determin 1 ☒ Certifying 2 ☐ Medical E	28e. Date of In (Month, Dation of be ned 28e. Place of It building, e physician: To the best caminer: On the basis and manner s	jury Year) 28/ njury - At home ofc. (Specify) t of my knowled of examinetion stated.	b. Time of trijury , farm, street, dge, death occ end/or investi	28c. Injury M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	yet 4 X Nursing Hyet Yes 2 No	th (Check only ome 5 Res 28d. Dascribe 28f. Location City or To	Yes 2X No one) idence 6 □Other how injury occurre (Street and Number wm, State) a ceuse(s) and mer, date and place, a	of deal 1 Ye or (Specify) ed or or Rurel Ro nner as state and dua to the	th? es 2□ No outa Number d. a cause(s)		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Dete of Deeth

3. Time of Deeth

Ukraine

20852

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

MARCH 4, 1999

Physician
/Medical
Examiner

1. Decedent's Neme (First, Middle, Last)

Funeral Director

the Maryland ò items 23a 72 hours after "natural", or Hygiene.

Baltimore, Maryland 21215-0020

Box 68760.

P.0.

Records,

Division of Vital

Physician /Medical Examine

and ettending physician that the deeth certificate be the signed by t peen hes page 2 certificate To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical In by Medical

Month YEKATERINA KHODAK 03.04.1999 4:35 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number 9. Birthplece (Steta or Foreign Country) 1□ M 2 □ F 219.39.6450 Usual Residenca of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐No Director MARYLAND MONTGOMERY GERMANTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? NONE 18701 SPARKLING WATER DRIVE #E 20874 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Dacedant of Hispanic Orlgin? (Specify Yas or No-lf Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐**X**lo If Yas, Give Yeer or Detas: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 end 2 should be filed will Department of Health and Mental Hygien Important: if item 27 is marked other than any injury or other traumatic event, if a once. CLOTHES DESIGNER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Meiden Surneme) YULIANA "UNKNOWN ANTON KVAK 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) YURI NAKSHIN/GRANDSON 377 GELDERLAND CT, OLNEY, MARYLAND 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 38uriel 2 Cremation 3 Removel from State JUDEAN MEMORIAL GARDENS 3.5.99 OLNEY, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Service Lice Nema and Addrass of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete intervel Betw Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) 1 HOUR MYOCARDIAL RUPTURE Due to (or es e consequence of): ACUTE MYOCARDIAL INFARCTION 2 DAYS Sequentially list conditions, if eny, leeding to immediate causa. Enter Undarlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) CORONARY ARTERY DIRSEASE 1 YEAR Physician/Medical Due to (or es e consequenca of): Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation

State Registrar 3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certified

an

DR. PANKAJ LAL 31. Date filed (Month, Dey, Year)

6 Could not be determined

1119 ROCKVILLE PIKE #100, ROCKVILLE, MARYLAND MAR 0 5 1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

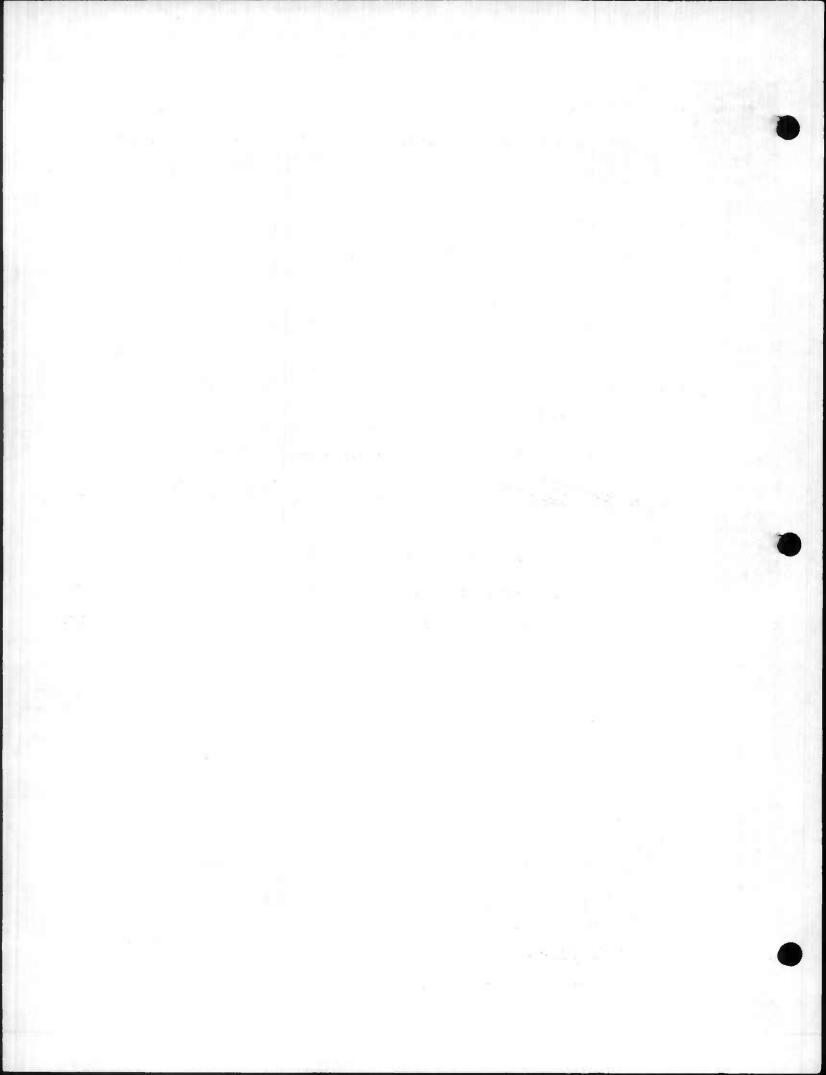
1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as steted.

2 Medical Examinar: On the basis of exemination and/or invastigetion, in my opinion, deeth occurred et the time, date end placa, end dua to the ceuse(s) end mannar stated.

29c. Licansa number

D39671

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate o	f Death	-	Reg. No		(LO	4 9 4
Γ	Dhunia		1. Decedent's Name (First, Middla, Las	t)					2. Data of De Month			ear 3.	Time of Death
	Physici /Medi		James F. Kme	tz					Februar		6, 19		2:40 PM
	Examir		4a. Facility Name (If not institution, giva	street end number)				4b. City, Town, o	r Location of Deat		. County of	-	
			Holy Cross Hospi	tal				Silver S	pring	М	ontgo	mery	
	Funeral		Social Sacurity Number 6. Sa	ix 7. Age	e (In yrs. last bi		If Under 1 Ya	ar if Undar 24 H	rs. 8. Date of Bir	th v. Year	9	Birthplace	(Steta or Foreign
	Director		185-24-8451	M ZUF	75	Yrs.			May 8,				lvania
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Loc	ation					10d t	nside City Limits
	Aenyt	5	-3.2-52										☐ Yes 212 No
	28a-	Directo	Maryland Montgom 10e. Street and Number	ery	Sil	ver	Spring			10a Ci	tizen of Wha		
	with or											at Country?	
	s 23	era	1010 North Belgra	de Koad 12. Was Decedent B	Ever in II S	13 W	209		Specify Ves or No	U.S		American in	dian
	fter d	Funeral	1 Never Married 2 Married	Armed Forces? 1 ⊠Yas 2 □ N	lo	if	Yas, specify C	f Hispanic Origin? uban, Mexican, Pue	erto Rican, etc.)			White, atc.	idian,
020	urs e	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1942- 1949	1	☐Yes 2∰N	o Specify:			Specify:	LTh i +	
21215-0020	be filed within 72 hours efter deeth with the Meryland nial Hygiene. Id other than "natural", or ferms 23a or 28e-f show event, the Medical Examinat must be notified at	Completed	15. Decedent's Edu			. Deced	ent's Usual Occ	upation		16b. K	ind of Busin	Whit ness/Industr	
215	hin 7	ple	(Specify only highest grad	fe completed) College (1-4or 5	+) T o	(Give k	O NOT use ret	ne during most of w ired) Represent	orking				
	d wil	5		4	Un	ited	Mine V	Jorkers o	f America	a	Labo	r Unio	on
Maryland	al Hygi I other	Be (17. Father's Name (First, Middle, Lest)					18. Mother's N	ame (First, Middla,	Meidar	Sumema)		
ya	2 should be filed end Mental Hygi Is marked other aumatic event, I	2	John Thomas Kmetz					Franc	es_Elizal	eth	Maur	kus	
a			19a. informant's Name/Relationship (T)	/pe, Print)	198	. Mailing	Address (Stre	et end Number or i	Pural Route Numb	er, City	or Town, Ste	ete, Zip Cod	20902
2	s 1 end 2 should f Heelth end Mer Item 27 Is marks other traumatic		Bernadine Theresa	Kmetz (wi:	fe) 10	10 N	orth Be	lgrade R					
0	H iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ F	Ramoval from State	20b. Place o cemate	f Dispos ry, crem	ition (Neme of atory or other p	lece)	Date		cation - Cit ticoke	ty or Town,	State
altimore,	Peg men ant:	:	4 ☐ Donetion 5 ☐ Other (Specify)		St. F	ranc	is Ceme	tery	03/2/99			ylvani	la
a a	permit. Peges 1 end 2 Department of Heelth e Important: If fem 27 la any injury or other tra once.		21. Signature of Funting Service Licens	00				fress of Facility J. Collin	s Funera	l Ho	me T	nc	
	40 = 60		Kosut	Kam	sey	50	O Unive	ersity B1	vd.,W.,S:	ilve	-		20901
			23a. Part1. Enter the diseese, or compleshock, or heart failure. List only o	icitions that caused ne cause on each lin	the death Do	not ente	r tha moda of d	ying, such as cardi	ac or raspiratory a	rrast,		App	roximate rvai Between
	Physician				/							Ons	et and Death
	/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death)	a Encephalo	opathy							6 7	veeks
		5		1	Due to (or as a	consequ	ience of):					6 -	1
	ted nsit	Examiner		_{b.} Hypoalbur								OW	reeks
	end al-tra	xai	Sequentially list conditions, if any, leeding to immediate		Due to (or as a	consequ	ience of):						
68760,	sicial bourd	call	cause. Enter Undarlying Cause (Disease or injury that initiated events	Renal Fa	ilure Due to (or as a							6.1	weeks
9	law requires that the death certificate be executed as been signed by the ettending physician and a 2 should be deteched for use as the burial-transit	Medical	resulting in death) Last		Due to (or as a	consequ	ence or).						
ŏ	eath cert ettendin for use	2		d									
D.	deat	sicie	Part ii. Other aignificant conditions cor	ntributing to death bu	it not resulting i	n the un	derlying cause	given in Part I.	23b. Did	tobacco	uae contri	bute to the	cause of death?
	res thet the designed by the e	Physician/							10	Yes 2	.□ No 3	☑ Probably	4 Unknown
Ś	es the	by	Chronic obstructi	ve pulmona	ary dis	orde	r	-	-				
D	v require been si should	ted							24a. Was	an auto	psy 2	availabl	utopsy findings e prior to
ပ္ပ	hes be	ple									1	of death	tion of cause
T	The ate h	Completed							10	res 2	₩ No	1 🗆 Yes	2 □ No
/11/2	Physician: The la r this certificate hes aral director, pege 2	Be	25. Was case referred to medical examiner?					26. Place of D	eeth (Check only o	ne)			
Division of Vital Records,	hysic his c	2	1 ☐ Yes 2 ☒ No	Hospital: 1X inpatier		utpatient	3LI DOA		Homa 5 Resid	dence	6 □Othar ((Specify)	
Z Z	Ing P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur (Month, Dey	Year) 28b.	Time of injury	28c. tn		28d. Describe	now inju	ry occurred		
S	Attanding or death. octor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No	006 1				
2	or Attanding Peffer death. Director: After t	Certification:	4 Homicide determined	28e. Place of inju building, etc	iry - At nome, te :. (Specify)	em, stre	et, rectory, offic	·0	28f. Location (a City or Tox			or Hurai Hoi	ite Number,
	pottai ours ours filled		29a. Certifier 1K) Certifying Phys	sician: To the best o	f my knowledge	death	nocurred at the	time, date and pla	no and due to the	001100/0	and mann	or so stated	
	Hos 24 h Fun etely	edicai		ner: On the basis of and menner ste	examinetion en	d/or inve	estigation, in my	opinion, deeth oc	curred at the time,	dete en	d plece, end	due to the	ceuse(s)
	To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier	7 /	1.1	1	29c. Lica	nsa number		29d. Da	te signed (M	Month, Dey,	Year)
			All	mulmal	elara	1111	D 00	220		1.1.		7 10	00
1	2		30. Name and eddress of person who co	ompleted cause of de	eath (item 23e)	(Type. P	D 02	200		epri	uary 2	27, 19	99
			Richard P. Delane					nue Silv	er Sprine	Ma.	rvlan	d 209	902
	Sta	te	31. Date filed (Month, Day, Yeer)	32. Registra	r's Signature	,				7 2.44	المرماني رري		-
	Registr	ar	MAR 0 2 199	Y Bear	wa	Ka							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend #10f, #15, 3/8/99, BMW, Montg Amend #7, 3/2/99, BMW, Montgomery Cty. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY ZWI KOSCZUK 28, 1999 1:01 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner 603 WEST EDMONSTON DRIVE ROCKVILLE MONTGOMERY Birthpleca (State or Foreign Country) If Under 24 Hrs If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 F Months Deys Hours Min 83 -84 Yrs. 112.38.0331 12.31.1915 POLAND Director Usual Residence of Decedent the Maryland 10d. Inside City Limits or 28a-f show 10a. Siele 10b. County 10c. City, Town or Location X Yes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or Items 23s or 603 WEST EDMONSTON DRIVE 20814 USA 20852 death Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 益☐ No If Yes, Give Year or Detes: Was Decedeni of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maniel Status pemit. Pages 1 and 2 should be filed within 72 hours after a Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or item any Injury or other treumatic event, the Medical Examinations. Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4or 5+) -n/an/a MANAGER 9 CONSTRUCTION 18. Mother's Name (First, Middle, Melden Sumame) 17. Fether's Neme (First, Middle, Last) Be ELIAHU KOSCZUK RASHE WEINER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) DALIA GILPIN/DAUGHTER 5225 POOKS HILL RD #821 S, BETHESDA, MARYLAND 20814 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) JUDEAN MEMORIAL GARDENS 3.1.99 OLNEY, MARYLAND 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate triterval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel ACUTE MYOCARDIAL INFARCTION diseese or condition resulting in deeth) **Examiner** Due to (or es e consequenca of): Examiner ARTERIOSCLEROTIC HEART DISEASE tha deeth certificata be executed physician and the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Box 68760 Physician/Medical Due to (or es e consequence of): for usa es 98 ed by the datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o signed by t 1 Yes 2 No 3 Probably 4 Unknown that NONINSULIN DEPENDENT DIABETES MELLITES, Records, þ The law requires 24b. Were autopsy findings available prior to been si 24e. Was en eutopsy Completed CHRONIC LYMPHOCYTIC LEUKEMIA completion of cause of deeth? is certificata has t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this funeral di 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 X Naturel death. 1 ☐ Yes 2 ☐ No after death Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide In 24 hour.
The Funeral Direction of the funeral direction of the funer 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end manner es steted 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Within 2 end manner stated. 29b. Signat title of certifie 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 31. Dete filed (Month, Dey, Year) MAR 02

STEVEN D. LERNER,

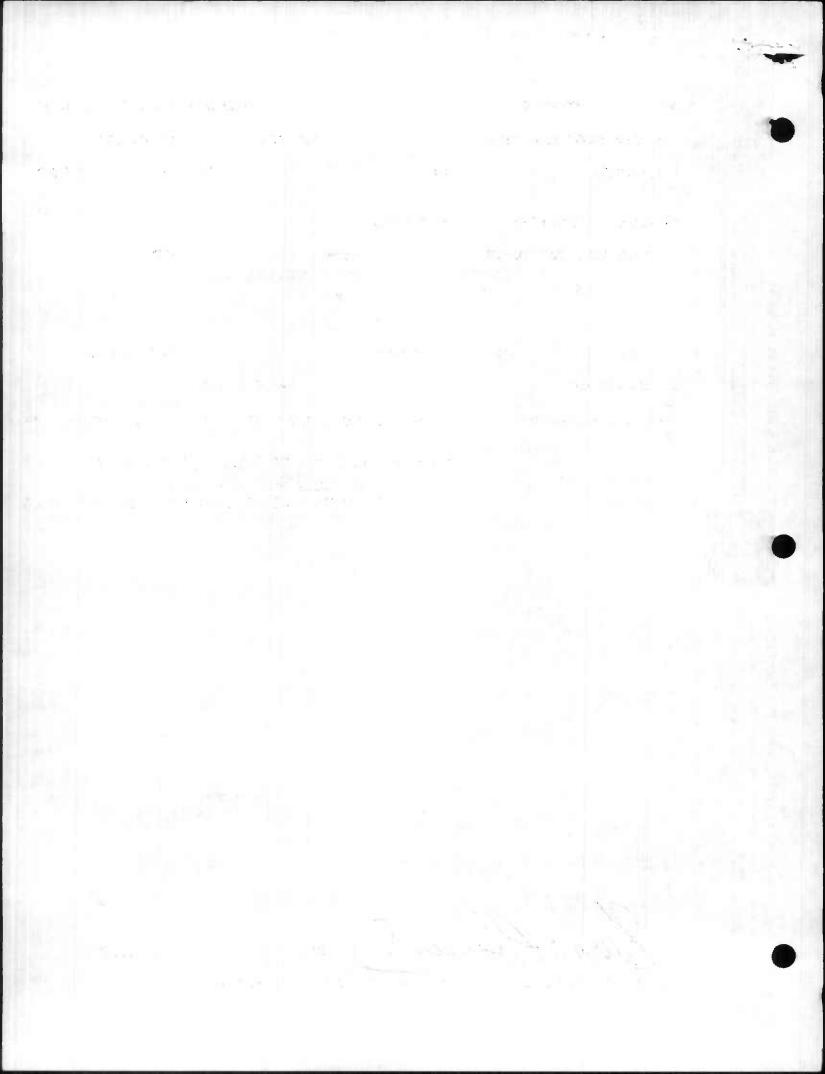
1145 19th ST, NW, #708, WASHINGTON, D.C. 32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Point

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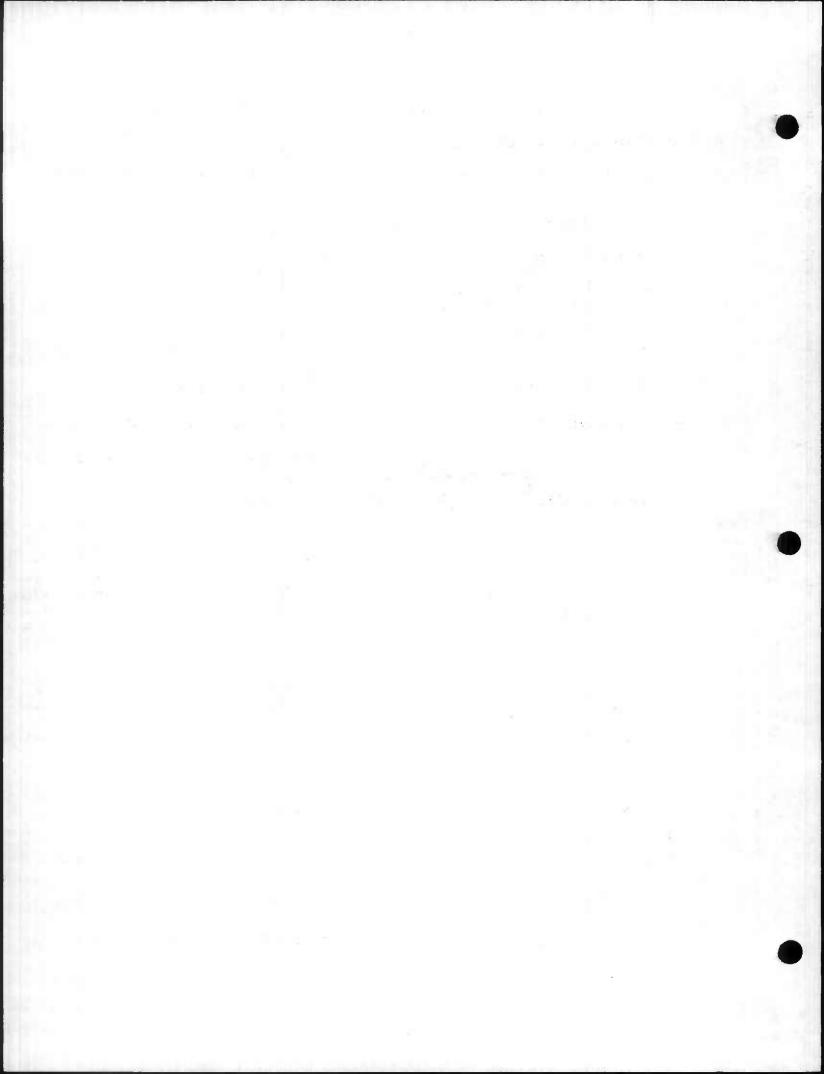


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Mental Plant Activities Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Mental Plant Activities Activities Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		Decedent's Neme (First, Middle,)		Reg. No. 3. Time of Deeth									
Physic /Med		JOHN	BLAIN		IRBY		MARCH	3 Dey 199	99 5:30 AM				
Exam	iner	4e. Facility Name (If not institution, g		OME			n, or Location of Dec TTE HALL	Oeeth 4c. County of Death ST. MARY 'S					
Funera Directo		5. Sociel Security Number 578-38-8697		a (in yrs. last bir	Yrs. If Under 1 Months			irth (2ay, Year) 4, 1914	9. Birthplece (State or Foreign Country) Pennsylvania				
*		Usuel Residence of Decedent 10a. State 10b. County	-	10c. City, Tow	n or Location				10d. Insida City Limits				
le merked other than "natural", or itema 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	to	MARYLAND CHARL	FS	lal	ALDORF				1 ☐ Yes 2√☐ No				
e not	olrec	10e. Straet end Numbar		, , , , , , , , , , , , , , , , , , , ,	10f. Zip C	ode		10g. Citizen of 1	Whet Country?				
Math	ral	2049 ROSEWOOD DE	RIVE			20601		U.S	S.A.				
Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 [A] Yes 2 [] If Yes, Give Year or Dates:	No1943-	13. Wes Daceda If Yes, specif		n? (Specify Yes or N Puarto Rican, etc.)	lo- 14. Rad Blad Specify	e - American Indien, ck, White, atc.				
ed cal	Completed	15. Decadent's (Specify only highast g	Education preda completed)	16e.	Decadent's Usuel (Giva kind of work iife. DO NOT use	Occupation done during most of	of working	usiness/Industry					
The Man	dmo	Elementary/Secondary (0-12)	Cotlege (1-4or 5	5+)	Analyst	161160)		Federal	Government				
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etic e	To	Edward Wilso	on Kirby			Mart	na Washin	gton Bla	in				
traumetic		19a. Informent's Neme/Reletionship					or Rural Route Num						
See.		Michael Lauer/Nep	hew		49 ROSEWO f Disposition (Neme ny, cremetory or oth		, Waldorf	-	nd 20601 City or Town, Stete				
Important: If Item any Injury or othe once.		1 Description 3 Remove from State 4 Donetton 5 Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Tuneral Home, Inc.											
5 5 6	Si .	DAVID A. GOFF P.O. Box 156, Waldorf, Maryland 20604											
		23a. Pert1. Entar tha disease, or co shock, or heert feiture. List on	mplications thet caused ly one ceuse on each li	the deeth. Do	not enter tha moda	of dying, such es ca	ardiac or respiretory	errest,	Approximate Interval Between				
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-trans	Examiner	Sequentietly list conditions,	D		consequenca of):	777500							
burial-transit	m m	Sequentietly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events	ONE YEA										
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for use a	an/N		d										
ed to	Physician/M	Pert II. Other significant conditions	contributing to death be	ut not resulting in	n tha underlying cau	ise given in Pert I.	23b. Di	23b. Did tobacco use contribute to the cause					
ned by the a detached f	Phy	DEMER	1774				10	Yas 2□ No	3 Probably 4 Unknow				
should be del	Completed by		ROVASU	LLAR	ACCI.	DENT	24e. We	es en eutopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?				
page 2	E O						10	Yes 2 No	1 Yes 2 No				
ctor, p	Be C	25. Wes case referred to medical				26. Plece o	of Death (Check only	/ \	7.3.00 2.3.10				
director,	2	exeminer?	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpetient 3 DOA	Other: 4 Nurs	ing Home 5 Re	sidence 6 Oth	er (Specify)				
e funeral	ation:	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigat	28d. Describe	28d. Describe how Injury occurred									
completely filled in by the	Certification:	3 Sulcide 6 Could not determine	be d 28e. Place of Inju- building, etc	ury - At home, fe c. (Specify)	rm, street, factory, o	offica		(Street end Numb own, Stete)	per or Rural Route Number,				
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29e. Certifier 1 Certifying F (Check only one) 1 Medical Ext	Thysician: To the best of aminer: On the besis of end manner sta	examinetion en	, death occurred et d/or Investigetion, Ir	the time, date end my opinion, death	plece, end due to th occurred et the time	e ceuse(s) end me e, date end plece,	enner es steted. end due to the ceuse(s)				
Toth	M	29b. Signeture end title of cartifier	chad a	huana		License number 5065	3		d (Month, Dey, Yeer) 3 - 99 -				
		30. Neme end address of person wh	o completed cause of d			21							

B. Sparks

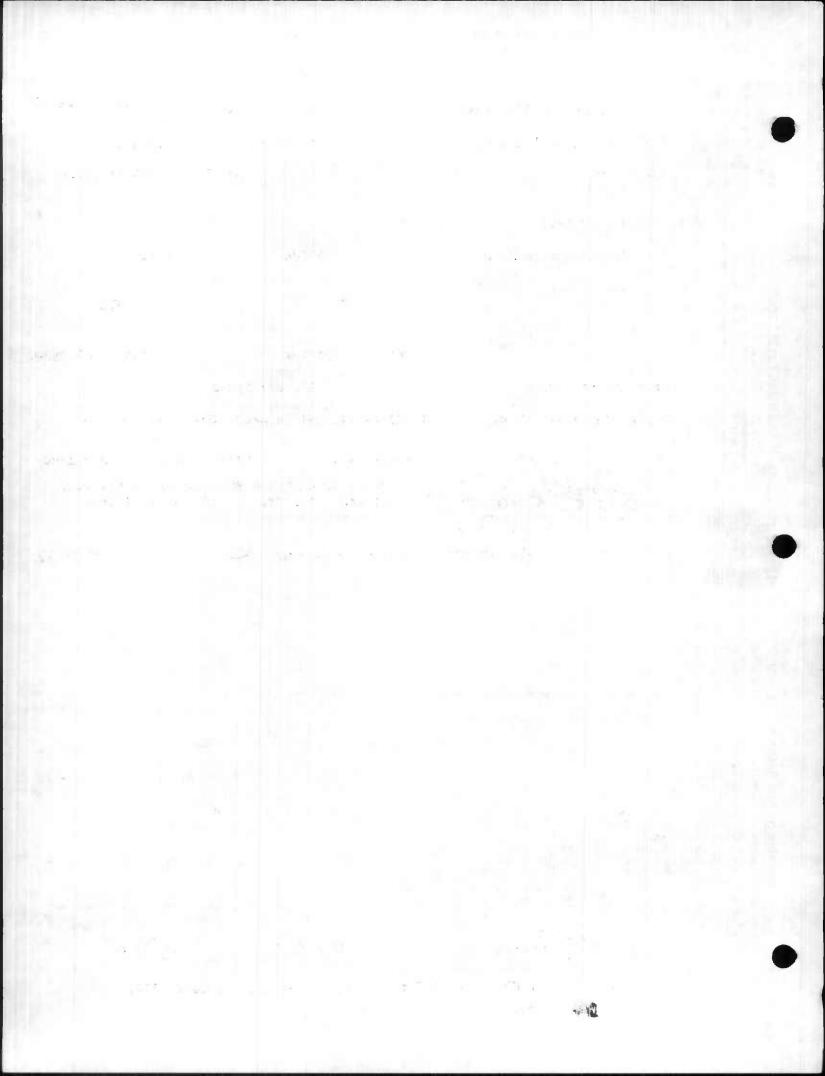
State Registrar 31. Dete flied (Month, Dey, Year) MAR 0.5 1999 32. Registrer's Signeture



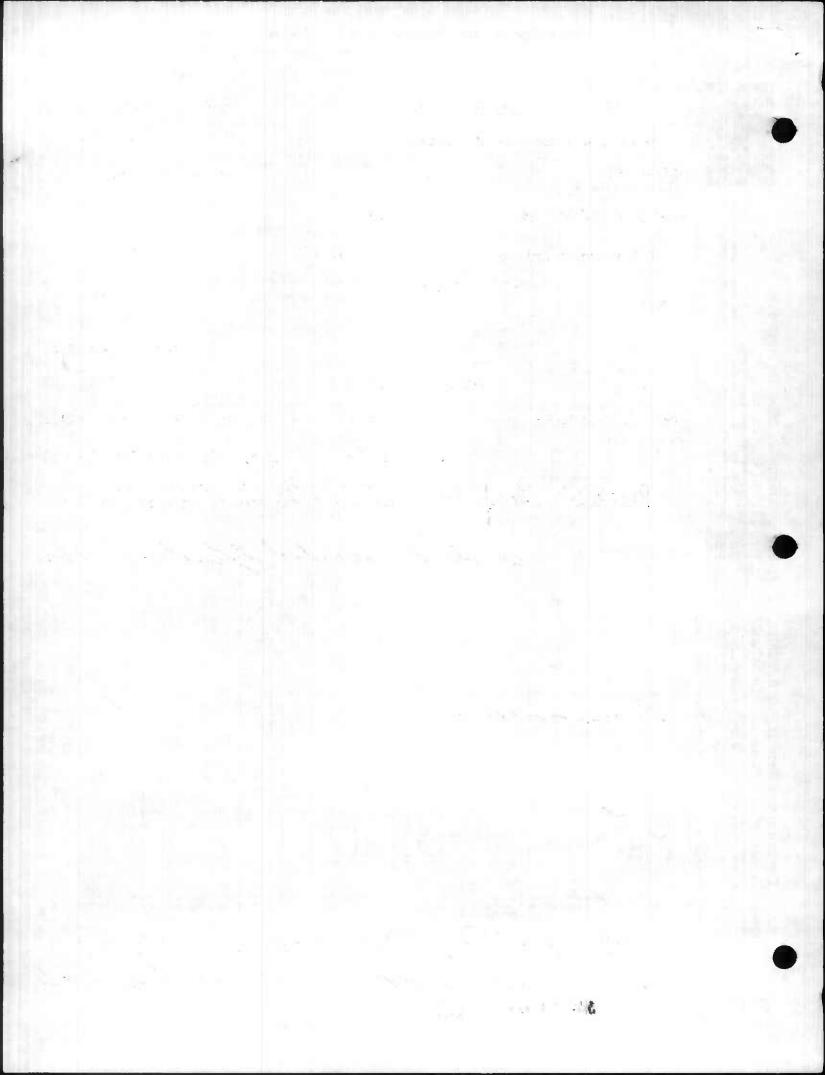
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth Month **Physician** 12:45 PM HARRY ROBERT KERNS 1999 March 6, /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 14821 Sabillasville Road Thurmont Frederick 6. Sex 12 M 2 □ F If Under 1 Year If Undar 24 Hrs. 6. Dete of Birth (Month, Day, Year) April 27, 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Deys Hours Min Yrs. 43 1955 Maryland Director 212-62-2502 Usuel Rasidenca of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and process. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland | Frederick Thurmont 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14821 Sabillasville Road 21788 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, Whita, atc. 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 🕅 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Senior Carpenter Construction Company 18. Mother's Name (First, Middla, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Harry Robert Carson Ada Mae Kerns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Shirley Setherley (P.R.) 14821 Sabillasville Road, Thurmont, MD 21788 20b. Place of Disposition (Nema of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State Welker Cemetery 3/9/99 4 ☐ Donation 5 ☐ Other (Specify) Thurmont, Maryland 22. Name and Addrass of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 23a. Pert1. Enfor the disease, or complicetic shock, or heart failure. List only one ca eth. Do not enter the mode of dying, such as cardiac or raspiretory errest, **Physician** /Medical Immediate Cause (Final RENAL CELL CANCER YETASTATIC disease or condition resulting in deeth) Examiner Due to (or es a consequance of): Examiner physician end the buriel-trensit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate causa. Enter Undarlying Cause (Disaasa or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) 80 USB signed by the e Part II. Other alunificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yas 2 No þ 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed irector, pege 2 s 1 □ Yes No 21/ No 1 ☐ Yes or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) To F Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: Affer 1 Naturel
2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No r death. invastigation efter deat 1 24 hours effer des Ne Funeral Director 6 Could not be 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi edical (Check only one) 29c. License number 29b. Signetyre)and title of certifies. 29d. Date signed (Month, Day, Year) 031761 MD 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Brian M. O'Connor, MD 501 West 7th Street, Frederick, Maryland 21701 1990 Signature 31. Dete filed (Month, Day State Registrar

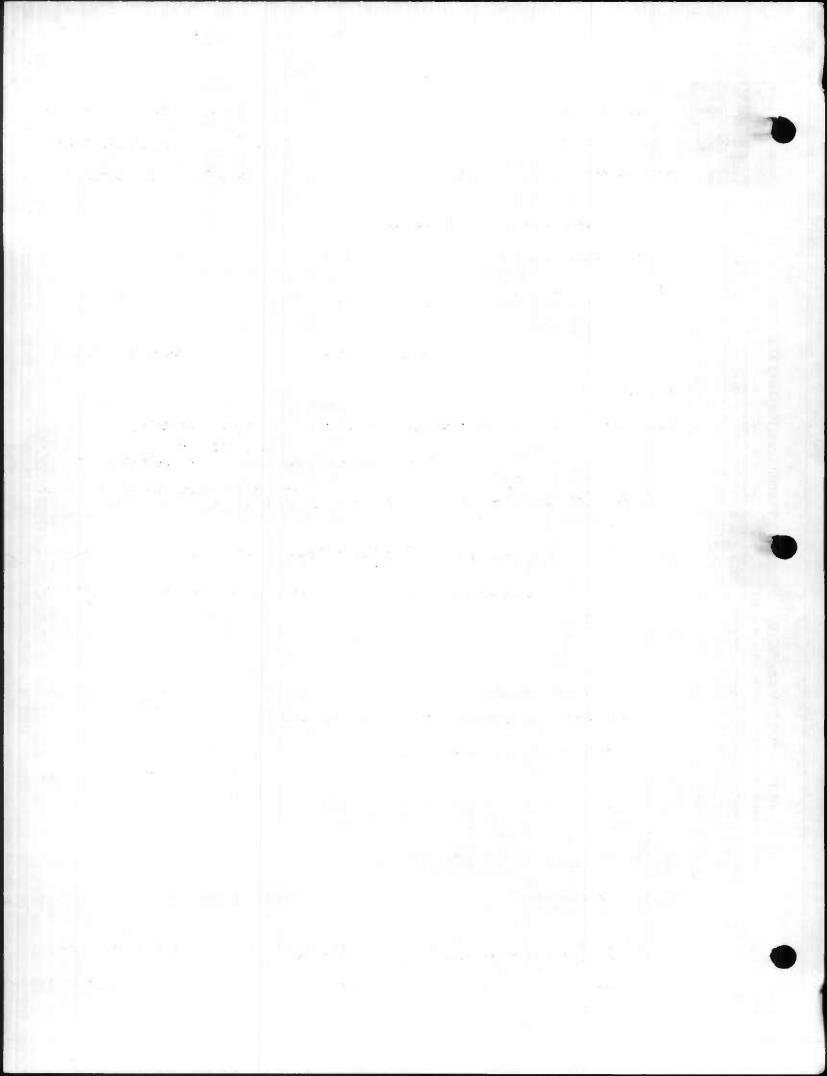


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		Frederick Mer 5. Social Security Number 6.		SPITAL (In yrs. last birtho	foul If Und	er 1 Year	Fred				eder		or Foreign		
	Funeral Director		120 M 2□ F	87 Yr	Month			Min.	8. Date of Birth (Month, Day Dec 14	, 1999	Mich Mich	nigan	or Foreign		
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	ith with the Marylar 23a or 28a-f show ust be noutled at rai Director	10e. Street and Number 1139 Eisenhower	Drive	10f. Zip Code 15076					1		of Whet Country? J.S.A.				
020	urs after des ult, or ttems anner m by Fune	11. Maritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 1 2 Yes 2 □ N If Yes, Give Yeer or Detes:	1942- If Yes, specify Cuban, Mexice				n? (Spec Puerto P	cify Yes or No- tican, etc.)		e - America k, White, e : Wh				
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	and 2 sho salth end 127 is me er traums	19a. Informent's Name/Reletionship Rose G. Graf/Dau			-					cick, Ma			1702		
Baltimore	Pages 1.	20e. Method of Disposition 1 X Buriel 2 Cremetion 3 C 4 Donetion 5 Other (Special		cemetery.	ece of Disposition (Neme of metery, cremetory or other plece) er Creek Cemetery Mar 5, 1999						20c. Location - City or Town, State				
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		30. Neme and eddress of person who	completed cause of de	eeth (Item 23e) (T	ype, Print)	30	0 h	1, 9	りからな	to Free	leru	les m	rd.		
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State of Maryland / Department of Health and Mental Hygiene 🔾 🔾

							Cert	ificate o	f Deatl	ר	F	Reg. No.	J U	84	99
		1. Decedent's Name (First, I	fiddle, La	ist)							2. Dete of Dee	Dete of Deeth Month Day Year		3. Tim	a of Death
Physic		Joseph P. K	nell								Feb.	20 , 1		7:4	4 PM
/Medi Exami		4a Facility Neme (If not inst		e street end nu	mber)				4b. City, 7	own, or Lo	ocation of Death			7 . 1	7 2 2 2
LAGIIII	IICI	Sinai Hospi	rc1						Po	ltimo	***	D-1+	imore	Cit	- 37
E	`	5. Social Security Number		Sex	7. Age (In yr	s. lest bin	thday)	If Under 1 Yes		or 24 Hrs.	8. Dete of Birtl	1			
Funeral Director		219-16-4542		1\0000MM 2□F	74		Yrs.	Months Dey	s Hours		(Month, Day Jan 27	r, Year)	Mary		te or Foreign
P.		Usual Residence of Decede			40- 4	Olar Tarre		ation a					- 4	0-1 114	- Ola - Limite
ahov I	_	10a. State 10b. Co	unty		100.	City, Tow	1 or Loca	ition					1		e City Limits Yes 2 □ No
M P	cto	MD Bal	timo	re City	Ba	altin	nore							101	62 2 140
\$ 50 E	Sire	10e. Street and Number						10f. Zip Code	9			10g. Citizen of	What Coun	itry?	
23a	al	4615 Park He	ight	s Avenue	2			212	15			U.S.A.			
9 E 5	Funeral Director	11. Maritel Status		12. Was Dec	edent Ever in	U,S.	13. W	as Decedent o	f Hispanic C	rigin? (Spe	ecify Yes or No- Rican, etc.)	14. Rec	ce - Americ		h,
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, its Medical Evans or mart be notified and any injury or other traumatic event, its Medical Evans or mart be notified.	by Fu	1 X Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		1 X Yes	2 No	aan		Yes 2X N			ricall, etc.)		by: Whi		
hou	8			ducation	oloo. KOI e		Decede	nt's Usual Occ	cupetion			16b. Kind of B	usiness/înc	dustry	
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filed within Hygiene. ther than	E	Elementary/Secondary (0-	12)	College (1-4or 5+)	De	live	erv Cle	rk			Transp	ortat	ion	
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2 st		19a. Informant's Name/Rela									el Route Numbe				
and ealth T 27		Theresa Kne	11 -	Sister-						Driv	e, Gras				
of H		20e. Method of Disposition 1 Burial 2 □ Crema	ion 3.	Bemoval from		cemeter	y, creme	tion (Neme of story or other p	olece)	Fe	b. 26,	20c. Location	- City or To	wn, State	à
Pages nent of int: If its iry or o		4 □ Donation 5 □ Oth) Vet	. Ce	emetery	-Crow			Crownsv	ille,	MD	
permit. F Depertmental Importan any Injur		21. Signature of Funeral Se	y/co Ligo	naglo ~ /				Name and Add				77	1 1		-
89 5 5 8		Amis	6/	were	leve						& Newn			lome	P.A.
_		23a Part Enter the disease, or complications that caused the coath. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or head failure. List only one cause on each line.													mate
Physician		23a. Plant: Enter the disease, or complications that caused the chath. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death													nd Death
/Medical		Immediate Ceuse (Final disease or condition ACUTE RESPIRATORY FAILURE											i	Ad at	URS
Examiner		disease or condition resulting in death)		8. // C					1 DICC	1	11-4	RC		110	Y rcj
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and and	хаг	Sequentially list conditions, if eny, leading to immediate			Due to	(or es e	conseque	ence of):					i		
be e	<u>=</u>	Cause. Enter Underlying Cause (Disease or Injury	1	C									i		
iceta be executed physician and s the buriat-trensit	edical Examiner	that initiated events resulting in death) Last	1		Due to	(or as a	conseque	ence of):					i		
entifica ding pl			L	d									i_		
The law requiras that the death certificata be executed of has been signed by the attending physician and page 2 should be datached for use as the bunat-trensit	Physician/M														
the de	ysic	Part II. Other significant con	ditions	contributing to d	eath but not r	esulting in	the und	ierlying cause	given in Par	t I.		obacco usa co			
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The te he	E O										101	es 2 No	1[☐ Yes	2□ No
iffice	BeC	25. Was case referred to me	dical						26. Pie	ce of Deat	h (Check only o	ne)			
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Phy ral d		27, Manner of Death		28a. Date	of Injury	28b.	Fime of		njury et Vork?		28d. Describe h			,,	
After fune	io	1 Netural 5 □ P	ending restigation	(Mon	ith, Dey Year)		njury		Vork? ☐ Yes 2[TNo					
deat deat tor:	ca	3 ☐ Suicide 6 ☐ C	ould not t		of laius. At	home fo	rm etro				28f. Location (S	Street and Num	her or Run	al Route I	Number
or Al	Certification:	4 ☐ Homicide de	termined	build	ing, etc. (Spe	cify)	m, siree	et, fectory, offic	Ce.		City or Tow		Der or Hore	11100101	vonicor,
urs a lifed	Ö											75			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 Car (Check only 2 Med	ifying Pi Icat Exa	miner: On the b	asis of exami	nowledge nation an	, deeth d d/or inve	occurred et the estigetion, in m	s time, date a y opinion, de	and piece, eeth occurr	and due to the red at the time,	ceuse(s) end m dete and plece	, and due to	teted. o the cau	se(s)
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0 1 × 00	-	29b. Signature and title of ca	THIFF		1		0.4	_	ense numbe			29d. Date sign			
		1064	les	rerace	mt	MO	PA	1	136	64		7e6 .	23,	19	99
		30. Name end address of pe	rson who	completed caus	se of eath (It	lem 23e)	(Type, P	rint)							
		B C. VEI	JER	CACIO	NJA	MO	PA	1576	MEI	ERIT	T BLUK	OBA	470	MO	. 2/2-
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State of Maryland / Department of Health and Mental Hygiene O

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 24, 1999 6:05 AM Dorothea L. LaHayne /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1923 | Min. | March 12, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funerai** 1 ☐ M 2 🖾 F Washington, DC 578-20-0264 75 Yrs Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11934 Andrew Court 20902 USA Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Betts Catherine L. Russell 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (husband) 11934 Andrew Court, Wheaton, MD Robert E. LaHayne 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2/27/99 Silver Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Francis J. Collins Funeral 21. Signature of Funeral Service Licenses Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23a. Part. Enter the abase, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Meumonia Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): rid by Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 ★ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending February 18,1999 1 Yes 2 No Investigation 12:15AM tell 2 Accident at nome 3 ☐ Suicide 6 Could not be determined Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office

28e. Placa of Injury - At home, farm, street, factory, office

28f. Location (Street and Number or Rural Route Number, City or Town, Sante)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cedse(s) and manner as stated. 29a. Certifier (Check only one) 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause 10M9/ 31. Date filed (Month, Day, Year) State MAR 01 Registrar

DHMH 16 Rev 6/95

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples name be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: If item 27 is marked other than any injury or other traumatic event, the Mean injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event, the Means injury or other traumatic event, the Means injury injury or other traumatic event.

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Faltimore, Maryland 21215-0020

